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ABSTRACT

With the assistance of a consortium of subcontractors and with additional support provided by the Commonwealth Fund, the contractor has produced a Master Plan for the Drew Postgraduate Medical School in Los Angeles. The Bureau on developing a scope of work defined its interest in this contract as a demonstration of the planning process by which an academic institution in an economically and socially disadvantaged area and the members of the community can collaborate in health manpower education programs to raise the level of health in the community. The final contract report, which is the Master Plan, is in three volumes. The findings and recommendations of those participating in development of the Master Plan are addressed to such items as mission and role of the Drew School, the question of community participation, the relationships of the Drew School with the Martin Luther King Hospital, problems of faculty recruitment, patient care and academic programs, projections of necessary personnel and facilities, recommendations on site and site development, and projections for necessary capital expenditures. Additionally, the process by which these recommendations were reached is described and documented. (Author)

ED 078795

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Master Plan

for the Drew Postgraduate Medical School Los Angeles, California

To Bureau of Health Manpower Education, March 1973

Contract NIH 71-4149

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
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Volume I: Summary Report

**Lester Gorsline Associates
Arthur D. Little, Inc.
Urban Workshop**

HE 004421

ABSTRACT

Final Report on Contract NIH 71-4149 to the Charles R. Drew Postgraduate Medical School

With the assistance of a consortium of subcontractors and with additional support provided by the Commonwealth Fund, the contractor has produced a Master Plan for the Drew Postgraduate Medical School in Los Angeles. The Bureau on developing a scope of work defined its interest in this contract as a demonstration of the planning process by which an academic institution in an economically and socially disadvantaged area and the members of the community can collaborate in health manpower education programs to raise the level of health in the community. The final contract report, which is the Master Plan, is in three volumes. The findings and recommendations of those participating in development of the Master Plan are addressed to such items as mission and role of the Drew School, the question of community participation, the relationships of the Drew School with the Martin Luther King Hospital, problems of faculty recruitment, patient care and academic programs, projections of necessary personnel and facilities, recommendations on site and site development, and projections for necessary capital expenditures. Additionally, the process by which these recommendations were reached is described and documented.



CHARLES R. DREW POSTGRADUATE MEDICAL SCHOOL

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April 17, 1973

OFFICE OF THE DEAN

Daniel Whiteside, DDS
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Dear Doctor Whiteside:

In compliance with the provisions of the Master Plan Study of the Drew Postgraduate Medical School, underwritten by NIH Contract 71-4169, I am pleased to submit 10 copies of this Final Report, including all volumes and appendices. The Final Report documents the activities, observations, processes, and findings of the Study--including projections for the emergence of the Drew School as a major component of the King-Drew Medical Center.

Volume I is a summary; Volume II comprises the text of the Master Plan; and Volume III contains the appendices.

The Summary Report, which we believe will have more utility to a broad audience than the three-volume Final Report, highlights the recommendations for strengthening Drew's administrative and leverage capacities, as well as projecting resources and personnel for growth.

We trust the report will enable the Bureau of Health Manpower Education to better assess our growth pattern, complexity, and opportunities for fulfillment of the institutional mission. This is germane to the definition of the attributes of an area health education center and delineates a pattern whereby the aggregates of an academic health sciences center are assembled as socially responsive increments.

Sincerely,

Mitchell W. Spellman
Mitchell W. Spellman, M.D.

MWS:am

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SUMMARY REPORT - SECTION 1: THE DREW SCHOOL

SUMMARY REPORT

1. THE DREW SCHOOL

In 1966, one year after the Watts rebellion, The Charles R. Drew Postgraduate Medical School was incorporated. That same year, in response to community demand for a major health facility in south-central Los Angeles, the Martin Luther King, Jr., General Hospital was incorporated. King was opened in 1972. It is licensed for 394 beds.

The Drew School considers its mission to be to raise the level of health of its community. The Drew School, which is the academic partner of the King-Drew complex, is the extension of the King Hospital into the community.

The composition of this community and of the King-Drew "service area" is changing radically. Until 1973 the service area included some 340,000 persons, mostly black and of the lower socioeconomic levels. As a result of the County's current regionalization plan, this service area may expand to include more than a million persons, with significant increases in the percentages of Mexican-Americans and whites, and a relative decline in the percentage of blacks. There will also be shifts in socioeconomic levels as a consequence of redistricting.

A major commitment made by the school, through the department of Community Medicine, has been to determine the health service requirements and needs of this community and to set standards for evaluating change. This task is complicated by the changing definitions of the community which the King-Drew medical center is expected to serve.

Under contract with Los Angeles County, Drew faculty serve as the medical staff of the King Hospital and this hospital, in turn, is the setting for the school's educational, research, and patient care programs and services. Each faculty member has a joint appointment in one of the two medical schools associated with Drew, UCLA and USC. Drew department chairmen are chiefs of the corresponding clinical services of the King Hospital. The Drew faculty trains house staff, physicians assistants, allied health professionals, nurse practitioners, and community health workers. About 200 residents and students are now enrolled in these programs.

Drew is a private non-profit corporation governed by a board of directors that includes local residents, both lay and professional; the medical society; the affiliated medical schools; and individuals of national prominence. Mitchell W. Spellman, M.D., Ph.D., was appointed Dean in November, 1968. Nine department chairmen have been appointed; four are black, one is a Mexican-American. Approximately eighty full-time faculty members have been recruited; about half are black or Mexican-American. Ten Los Angeles physicians have full-time appointments; half are black or members of other minorities.

Initial funds to support the school during faculty recruitment were provided by a three-year grant from the California Committee on Regional Medical Programs. The sources of Drew's current operating funds are the County contract and numerous grants that support a variety of departmental and interdepartmental programs. The most immediate limitation on the expansion of Drew is the critical shortage of unrestricted funds available for that development. The survival, let alone the expansion, of Drew remains the persistent problem.

SUMMARY REPORT - SECTION 2: THE MASTER PLAN STUDY

2. THE MASTER PLAN STUDY

In the spring of 1970, the Drew School solicited proposals for professional assistance in planning its future. The contract for these services was awarded to a consortium composed of Lester Gorsline Associates, The Urban Workshop, Inc., and Arthur D. Little, Inc. This contract was funded by the Commonwealth Fund and the Bureau of Health Manpower Education (BHME) of the National Institutes of Health, Department of Health, Education and Welfare.

BHME defined its interest in the work as a demonstration of "...the planning process by which an academic institution in an economically and socially disadvantaged area, and members of the community can collaborate in health manpower education programs to raise the level of health in the community." The Drew School, in addition, desired a "master plan" that would recommend procedures for achieving community participation, program development, organizational structure, the projection of resources required (land, space, personnel, and funds), site development, and the phasing of new construction.

Thus, the study was expected to satisfy both the procedural interests of the federal government and the substantive concerns of the Drew School. The work was divided into two phases in response to funding requirements. Phase 1 concluded in March 1972 with submission of a report largely devoted to evaluating the experience of the school and the study team in attempting to enlist community participation in Drew's planning. Preliminary inventories and projections of current and proposed programs, as well as initial estimates of necessary resources, were completed in Phase 1 as a basis for further development during Phase 2.

The present three-volume report concludes Phase 2 and constitutes the "master plan" called for by the contract. Its findings and recommendations are summarized in this document (Volume I). A second document (Volume II) presents more detailed descriptions of these findings, and Volume III incorporates supporting documents of the study as appendices.

SUMMARY REPORT - SECTION 3: FINDINGS AND RECOMMENDATIONS

Mission and Role
Community Participation
The King-Drew Medical Center
Faculty Recruitment
Patient Care Programs
Academic Programs
Personnel Projections
Facilities Program
Site Development System
Capital Expenditure

3. FINDINGS AND RECOMMENDATIONS

3.1 MISSION AND ROLE

The mission of the Drew School as expressed in many documents, public statements, and interviews is to raise the level of health of its community. As expressed in the report of the Ad Hoc Committee on Appointments and Promotions:

The Drew School was founded to serve the health needs of a community through a comprehensive system of clinical services, educational programs, and research activities.

Or, as stated in "The Drew Medical School Concept," written by the school in the spring of 1971:

The Drew School will, in concert with its community, adapt the traditional activities of a medical school... to serve the health and welfare needs of that community.

In its emphasis on service to its immediate community, Drew differs from many other academic medical institutions who do not view their primary constituencies as particular population groups and who have as ends, not means, such activities as clinical services, educational programs, and research.

This role has been endorsed by the school's administration and faculty. Interviews and questionnaires analyzed by the study team indicated little disagreement within the school on this central issue. It is the principal criterion for evaluating program development.

Drew's mission has not, however, been as widely understood outside the school. Community interests more often see the school as an advocate of special concerns, a local action agency, or a source of jobs. These are necessarily concerns of Drew; but they also represent social and economic demands to which Drew can make only limited responses. As a medical complex, King-Drew recognizes that such issues as high rates of unemployment, low income, poor transportation, and depressing physical decay represent the basic problems of its community. But as a medical school, and particularly as an emerging institution, there are few solutions Drew can offer for these global problems.

Drew's effect on the economy of the service area is necessarily an indirect one. Drew has only a limited number of jobs at its disposal, but it can contribute to the economy of its community through training residents in the various health professions thus increasing their marketable skills. Drew can also encourage and assist local entrepreneurs in establishing appropriate business enterprises which will be needed around the King-Drew complex. Drew's principal focus is, however, on health; it is not and cannot be principally a community action or economic development agency.

Difficulties in carrying out the stated mission will also reflect continuing difficulty in defining this community. However its principal service area is defined, Drew also recognizes a state and national community, as well as responsibility to a local population. Relating the requirements of these diverse responsibilities to severely limited resources has been, and will continue to be, the school's primary concern. First priority consideration among these various responsibilities should, however, continue to be focused on the needs of Drew's immediate community.

We concur that one of Drew's most important roles is to act as an extension of King Hospital into the community. Drew, as a private institution, can act more independently than King, which must operate within the constraints of the County health system. We encourage Drew to continue its efforts to define, jointly with King Hospital, consumers, and third party payers, a community health delivery system and to document community health care needs. We recommend such joint development of health service centers offering primary ambulatory care and located off-campus within the community as satellites of the Medical Center, for whom staff, back-up and referral assistance are provided by King-Drew. We see this as an opportunity for Drew to engage the local professional community in joint planning for such "outreach" services. We encourage the school to locate training programs off-campus in such centers, in affiliated hospitals and local care institutions, community colleges, neighborhood facilities, etc., to merge school and community, to expand school programs, to increase their visibility, and to improve the quality of local care.

3.2 COMMUNITY PARTICIPATION

We recommend the following as specific means by which the

Drew School can actively engage community members in joint program planning and implementation required to carry out this mission:

- Secure greater participation of community physicians by continuing to appoint them to faculty positions.
- Continue and expand the membership of community residents on program planning task groups started during the Master Plan Study.
- Give greater recognition to the contributions made by community residents to the development of the school.
- Encourage the continued participation of Drew faculty and staff in community-based activities of all kinds, ranging from agency meetings to cultural events.
- Continue to establish mutually supporting and cooperative relationships with existing health care programs in the community.
- Through Drew's contacts with educational institutions in the region, actively sponsor students from the service area to those institutions, pressing for scholarships and other financial assistance where needed.
- Engage community residents in the development of a curriculum for consumer education programs aimed at helping residents to deal more effectively with health care professionals, health care organizations, and with the politics and economics of health.
- Engage community residents in helping to design a component of educational programs aimed at making health care professionals more aware of the life situations of patients, stressing equity of health care delivery, recognition of cultural differences, and improving the patient's ability to participate actively in his own course of treatment.
- Continue the planning process, started by the department of Community Medicine, of developing a health care delivery system for the service area through a series of discussions with community residents, local physicians, and fiscal intermediaries.

- Through the department of Community Medicine, continue efforts aimed at gaining greater knowledge and definition of the community and its needs, and forming coalitions and effective linkages with community agencies and organizations.

3.3 THE KING-DREW MEDICAL CENTER

Satisfaction of community health service requirements (as both the community and its requirements are defined) is a joint responsibility of King and Drew. Recognition of limited financial resources available or foreseeable makes all the more imperative the objective of creating, over time, a single Medical Center composed of the school, the hospital, and the network of satellite facilities.

Positive steps have been taken to unify Drew and King. Retreats have been held for both staffs to identify, discuss, and resolve mutual problems. A King-Drew Medical Center Committee has been established. These are beginnings. We are well aware of the apparently insuperable obstacles, principally the lack of money and the nature of County restrictions, inhibiting the long term development of a single center. But we assume that an ad hoc center already exists, and we recommend that formal establishment of a King-Drew Medical Center be adopted as the long range goal of governance and administration.

Developing new and better methods of delivering health care calls for developing new methods of administration and control. We recommend that another long range goal be the eventual creation of a joint King-Drew board of regents to govern the medical center. We recognize that such a joint board, controlling policy and finance, is not possible in the present administrative and legal framework. In fact, the conditions under which it could be done now would be detrimental to both the Drew School and its community. If it were attempted under current constraints, it would be necessary, in effect, to move the Drew School into an even closer control relationship with the County. The cost to Drew now would be loss of autonomy and its own board, including the community representation on that board. This is not acceptable. As a private institution, not under the control of the County, Drew has the power and the flexibility to assure that local community residents and practitioners have a voice in the operations of the school. Long range unification of the school and King Hospital must respect and preserve

this arrangement. Recognizing that, over time, things do change, and that new solutions require new organizational patterns and relationships, we urge the Drew School and King Hospital to work together to create, in the long term future, a climate of decentralized or delegated County authority which would enable a true medical center organization to exist. We urge both institutions to explore during the coming years the means of making the board of regents possible.

We recommend that, in time, a chief executive officer of the Medical Center be appointed to report to this board. This officer would have executive authority for the governance and administration of the Medical Center. Financial support for this office should be provided by both the hospital and the school.

Our recommendation that an office of planning and development be established in the Drew School has been approved in principle by the school's board of directors. A primary purpose of this office is to encourage and provide a mechanism for the development of interdepartmental or school-wide programs. This kind of program planning will be increasingly required as health problems are addressed which do not fit neatly into a single department's or discipline's jurisdiction. We further recommend that when this office has been established, its activities be closely coordinated with the King Hospital to provide a setting for inter-institutional as well as interdepartmental program development, thus advancing the concept of a true center. The ultimate objective is a medical center office of planning and development with center-wide responsibilities and support.

This office is not a panacea for all problems. To assist it, we suggest creation of a Medical Center Committee whose task is to review (at least annually) and evaluate all center programs and recommend programs for development. This committee should be composed of the director of planning and development, the hospital administrator, the dean of the Medical School, the dean of Allied Health Sciences, the director of Continuing Education, and the director of Consumer Education, assisted by others as required.

Under the long range medical center organization, we recommend that the hospital administrator or the director of clinical services be responsible for all hospital programs and report to the chief executive officer of the Center; that the dean of the Medical School be the director of the departments and report to this executive and have responsibility for administration of all residency programs;

that the dean of Allied Health Sciences also report to this executive and have responsibility for these joint King Hospital-Drew School programs; that the directors of Continuing and Consumer Education also report to the chief executive of the Center and have principal authority for direction of these joint programs.

The organization we propose as a long term goal directly relates the administrative structure to the major program categories of the Center (see Sections 3.5 and 3.6 below) and is illustrated on the following chart. We are well aware that this suggested long range organizational structure may raise more problems than it appears to solve. We view it as theoretical at this time, and only as one of several variations that could be devised to accomplish long range joint administration. We urge the Drew School to explore with the County (at both the King Hospital and the Department of Health Services levels), the various alternative ways in which a true medical center operation could be achieved in the future to the satisfaction of all parties.

Organization takes time and should not be permitted to preclude more immediate steps towards earlier integration at working levels. Both the office of planning and development and programs of allied health sciences are immediate opportunities to begin creation of a true center concept.

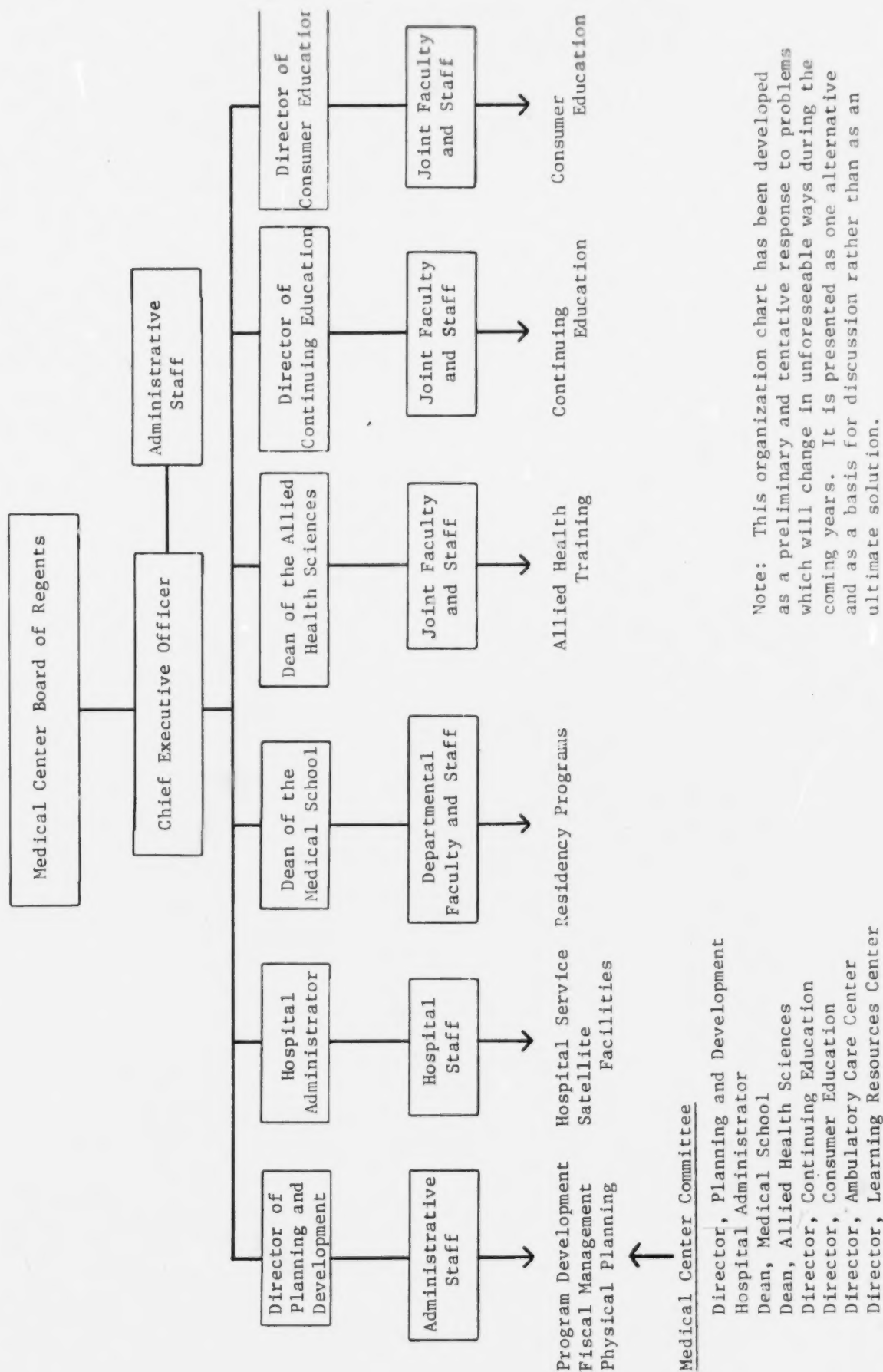
3.4 FACULTY RECRUITMENT

At its inauguration, Drew's board of directors decided the school's senior faculty would be recruited on a national basis rather than only from the medical community of south-central Los Angeles. This decision reflected a desire to recruit a faculty of capable clinicians and educators to give the new school credibility and stature.

This policy and its implementation have been viewed by many interested community leaders and community physicians as a denial by Drew that people of competence and stature can be found in the community. When interviewed by the study team, local physicians have argued that this faculty should have been drawn from the community it serves. That Drew has also recruited and appointed local practitioners to both full and part-time faculty positions is not yet fully appreciated.

We recommend that in recruiting faculty, Drew should look first

Figure 1
THE KING-DREW MEDICAL CENTER,
PROPOSED ORGANIZATION, LONG TERM



Note: This organization chart has been developed as a preliminary and tentative response to problems which will change in unforeseeable ways during the coming years. It is presented as one alternative and as a basis for discussion rather than as an ultimate solution.

Figure 3

PROPOSED ADMINISTRATIVE
ORGANIZATION, SHORT TERM

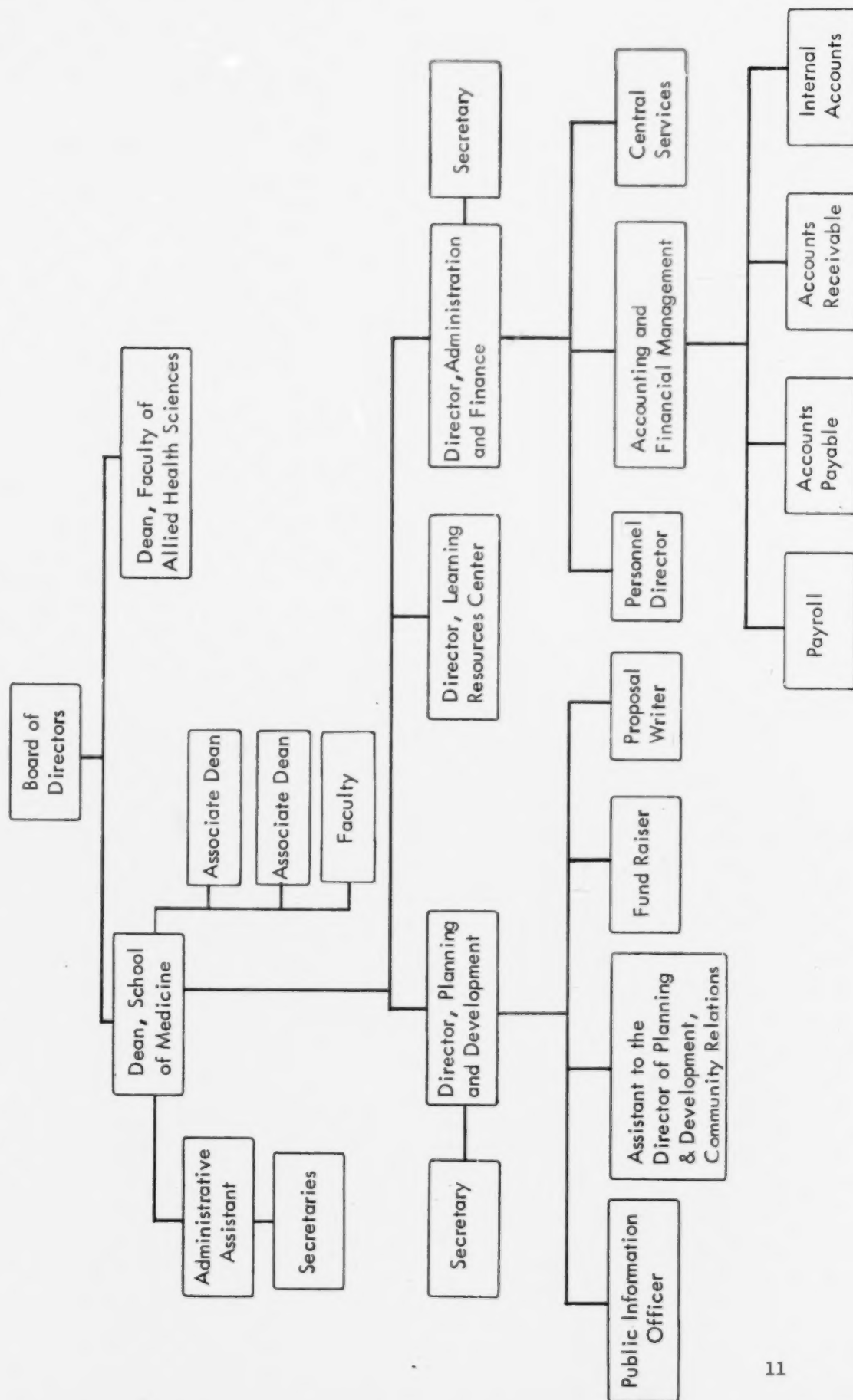
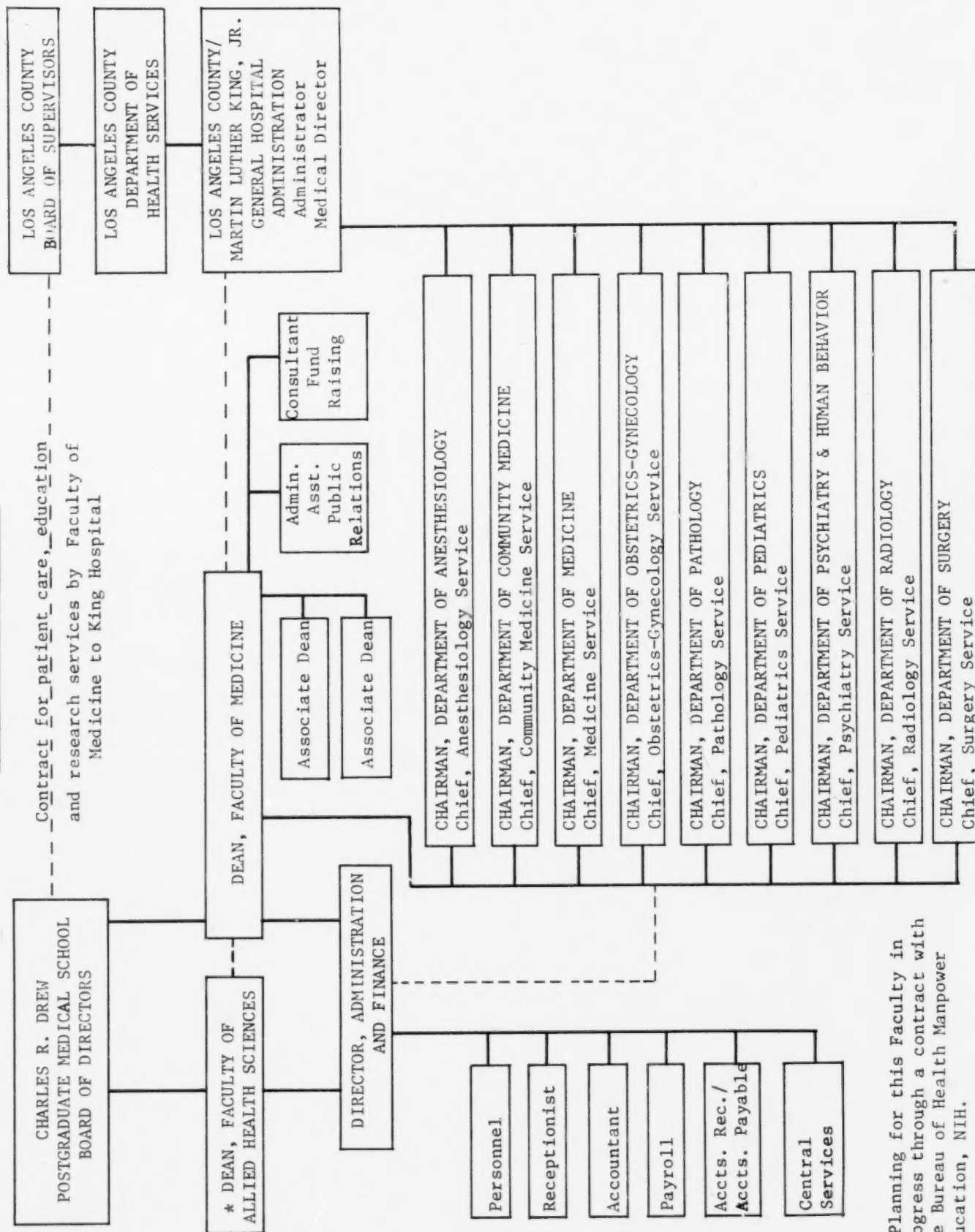


Figure 2
PRESENT DREW ORGANIZATION



* Planning for this Faculty in progress through a contract with the Bureau of Health Manpower Education, NIH.

to its immediate community, going regional and national in its searches only after it has exhausted the resources in the service area. It is important to continue to encourage wide participation by the local medical community in the affairs of the school and full-time appointment is only one mechanism (and, in fact, one not necessarily of interest to many practicing physicians). Voluntary or part-time associations related to school programs, and particularly to programs of continuing professional education and consumer education, can substantially increase local professional participation as well as maintain clinical and academic standards. We urge Drew to define clearly the part to be played by local physicians, including the setting of targets in terms of the numbers of such physicians to be recruited in the various categories. We note with approval Drew's decision to accord the same academic titles to full-time and voluntary faculty, rather than making the traditional academic distinction between professors and "clinical" professors. To its credit, the Drew School recognizes the unique contributions that local professionals can make to its programs, particularly in being able to specifically address problems in the community and transmit a wealth of first-hand knowledge and experience to those faculty and students who are "outsiders." We urge the Drew School to continue its efforts to draw on this resource and to convert this recognition into action.

3.5 PATIENT CARE PROGRAMS

In its first year of service, the King hospital has concentrated on acute care. As the major health facility of the neighborhood, and as the principal setting for Drew's programs, both the community and the school will benefit from the expansion of services that will inevitably accompany the growth of the medical center.

We concur in Drew's identification of two priority patient care activities: (1) planning for an ambulatory care center and (2) planning for a child care center with a clinical component. We recommend that this planning be carried on jointly with King Hospital.

The Master Plan Study stimulated and provided a framework for initiating planning for the development of a health care delivery system for the service area. In view of its stated mission, while recognizing many elements of a health care delivery system will be beyond its own control, Drew has a clear obligation to accept a leadership role in devising and implementing such a system. We

recommend that the department of Community Medicine be given the support necessary to complete this task.

Expansion of the services of King will be influenced by County plans and we therefore have endorsed the idea of joint King-Drew planning so that Drew may be a mechanism for extension of those services. However, in view of the comprehensive, County-wide plan for reorganization and regionalization of health services, Drew should also plan to coordinate its programs with those of the County at the level of the Department of Health Services. Expansion need not automatically mean new facility construction, nor facility construction at the medical center. We also encourage Drew to explore affiliations, use of other institutions or neighborhood facilities, and cooperative ventures with existing local providers such as the Watts Health Center.

Creation of an ambulatory care center and a child care center have been identified as priority programs for the Center. We recommend that planning for both proceed as a joint King-Drew effort. We believe the implicit emphasis on family practice is a response to felt community need and merits priority development. The community has made known its desire for more humanitarian care, emphasizing the need for training practitioners sympathetic to the population they are to serve.

We recommend creation of an ambulatory care center close to and coordinated with King Hospital in order to better serve the patient, provide an effective educational setting, and augment staff communication. On the basis of experience with hospital related ambulatory care programs, we urge the organizational and physical separation of the ambulatory care center from the hospital. If conservation of scarce physical and human resources were the main criterion, we would recommend maximum integration of the center and the hospital. We believe, however, that this would lead to an inordinate emphasis on the needs of hospitalized, acutely-ill patients, to the detriment of the ambulatory care center programs. If economic considerations require an immediate physical attachment of the ambulatory care center to the hospital, the risks inherent in such a situation should be noted and procedures established to avoid the tendency toward acute care domination which has plagued existing ambulatory care centers. (We have, for these reasons, indicated two alternatives for siting the ambulatory care center.)

The Master Plan Study also resulted in the identification of three high-priority program areas for the Drew School which have

both patient care and educational components: (1) drug abuse and alcoholism, (2) hypertension, and (3) maternal and child care. Preliminary planning for these program areas has been accomplished and initial goals and criteria for further program development have been established by task groups made up of people from King and Drew, consumers, and health professionals from the service area. We recommend that work in these areas be continued by:

- Reconvening and expanding the program development task groups established by the Master Plan Study steering committee
- Identifying key faculty members who can organize teams to lead the development of specific proposals to funding agencies
- Identifying appropriate funding sources to approach
- Developing and submitting specific program proposals.

3.6 ACADEMIC PROGRAMS

As with any institution of medical training, distinctions between patient care, training, and research tend to become arbitrary; each activity is required to support and enhance the other. All three are as much a part of Drew as they are a part of any such institution.

Drew's academic programs cover four basic areas encompassed as a "postgraduate" institution: residency training, allied health training, continuing education of local health professionals, and consumer education. One aspect of the emerging Drew program unique to it and its community is the emphasis on consumer health education. This is an emphasis we would like to see increased because we believe the direct education of individuals will have an immediate impact on the level of their health. The continuing education of health professionals will also yield direct benefits in improved health care.

Some 74 residents are now in training in residency programs in medicine, obstetrics, pediatrics, radiology and nuclear medicine, surgery, and psychiatry. 128 residents will be on board in July 1973. Additional residency programs are planned in community medicine, anesthesiology, and pathology. King Hospital and Drew School have agreed to coordinate a department of Family Medicine to administer

residency programs and coordinate joint programs with medicine, obstetrics, and pediatrics to train primary care physicians.

More than 100 students are enrolled in various allied health training programs such as emergency services, x-ray technicians, physicians assistants, recreational therapy placement, programs for nurse anesthetists, and child care workers. Lab technician programs are currently planned by pathology. Clearly an expansion of these programs is of interest to the community for their economic and medical benefits. We recommend that all program planning for education and training in the allied health professions be closely coordinated between the Drew School's faculty of Allied Health Sciences and King's Hospital Occupations Training programs. This will reduce the potential proliferation of overlapping, uncoordinated programs, provide for better use of limited resources, and support the planning of a greater variety of programs (including the training of health administrators, managers, and planners) in these fields. Ultimately, when a medical center organization is possible, we recommend one consolidated school of allied health sciences with responsibility for the planning and conduct of all such programs.

There are several programs of continuing education for health care practitioners and consumer education now under way. Programs of the former are given for physicians, nurses, dentists, and pharmacists in the area; the latter now includes a program of education for mothers and the training of community health workers. Mental health programs planned include training in crisis care, training for mental health planners, and Makauri (a program to train community residents to be mental health counselors). The opportunities for development of programs in these areas are considerable.

Of necessity, research has had a low priority in the initial years of the school. It is now, however, acquiring momentum with the submittal of a proposal for an education-oriented biomedical research program. A complementary grant of \$100,000 has been received from the Kaiser Family Foundation to serve as "seed" money to support young faculty investigators. Although the immediate benefits of basic biomedical research to the community are sometimes difficult to make plain, the benefits to Drew in terms of its intellectual enrichment are real, and in the end contribute to the effective performance of its service functions as well as to the creation of new knowledge. While we agree that laboratory-based research is a legitimate and important institutional activity, we expect that such research will not (and should not) develop at Drew to the same extent as it has at traditional medical schools.

It is our perception that the most relevant kind of research that Drew can undertake is that devoted to improving the delivery of care.

One benefit to the school of the work of the Master Plan Study has been to provide the first comprehensive inventory of current programs and to display what it is the school is, and is not, doing. Growth of the school (as may be normal for a medical training institution) has been from the department outward. Now that at least the departmental foundations have been established, it is apparent there is a need to concentrate future planning on interdepartmental cooperation and joint institutional efforts.

But the overriding limitation is money. It is tempting to observe (as one faculty member put it) that the Drew School is a collection of programs held together by indirect costs. Many of its programs are grant-supported at a time when grant funds are drying up. Significant attention to departmental cooperation is difficult to maintain when the dominant question is survival of programs and the school's mission.

A study by a subcommittee of the State legislature has proceeded to the point of discussions regarding the possibility of the State's providing Drew with a basic subsidy in the form of operational and program funding. It is expected that appropriate legislation will be introduced in the State legislature. This support is premised on the feasibility of Drew's expanding into undergraduate education.

The consultants do not recommend that Drew embark on a program of undergraduate education in the basic sciences because the initial and operating costs of facilities and staff are prohibitive. Nor do we recommend that undergraduate education of medical students, in whatever form, be given priority in the near term development of the Center. We do recommend that, if the school determines that in order to obtain funds it must offer undergraduate medical training, this training be limited to clinical education, with the student's pre-clinical work done elsewhere. (It should be noted that Drew is already providing clinical clerkships, supervised by Drew faculty, for students from other medical schools.)

In view of the reassessment of medical education that is now going on at many schools throughout the country, Drew could well undertake the organization of an integrated premedical and basic sciences curriculum at a college (or colleges) in the Los Angeles area. The clinical component of the curriculum would be taught by the Drew faculty at the King-Drew Medical Center.

3.7 PERSONNEL PROJECTIONS

The following table projects the full-time-equivalent (FTE) personnel required to support all programs now identified or planned by the school. Included are projections for both undergraduate medical programs (clinical plus basic sciences) assuming a class of 100 students. The development program shown is assumed only for purposes of demonstrating the incremental build-up of personnel required if all proposed programs become operational. "Steady State" is the projection of the numbers of faculty, staff, and students accommodated on campus when the building program has been completed and the facilities are occupied.

ESTIMATE OF PERSONNEL BUILD-UP, DREW SCHOOL

YEAR*	0	1	2	3	4	5	6	7	8	9	10	"Steady State"
Development Phase Completion					I, II	III	IV	V			VI	
Clinician Faculty	70	110	120	130	140	150	160	170	175	175	175	175
Allied Health Sciences Faculty	0	10	20	25	35	40	40	40	45	45	50	50
Basic Science Faculty	0	0	0	0	0	0	10	20	30	40	50	50
Administrators	12	15	15	15	20	20	25	25	30	35	40	40
Other Professionals	15	20	25	30	35	40	40	45	45	50	50	50
Clerical, Technical, Etc.	80	100	120	140	160	180	200	220	240	260	280	280
Allied Health Sciences Students	100	125	150	175	200	250	300	350	400	400	400	400
Undergraduate Medical Students - Clinical	0	0	0	30	50	70	100	125	150	175	200	200
Undergraduate Medical Students - Basic Sciences	0	0	0	0	0	0	0	0	25	75	150	200

* For purposes of demonstrating the incremental build-up of personnel in order to meet program requirements, we have assumed that the steady state will be reached in ten years.

3.8 FACILITIES PROGRAM

The following table projects the net square feet (NSF) of space required to house all programs now identified or planned by the school. Included are projections for both undergraduate medical programs (clinical and basic sciences) assuming a class of 100 students. The phased development shown is assumed only for purposes of demonstration. The sequence of Phases I through VI reflects the preliminary ranking of this building program by priority of need. The school has identified a learning resources center as its Phase I facility requirement. The function of this facility is to support all educational programs of King-Drew wherever such programs are carried out. It will have as its components a library, audiovisual production areas, professional services to assist faculty in the design of teaching materials, and study areas. An important component will be special collections comprising a cultural center for the enrichment of King-Drew personnel and programs and the community as a whole.

DREW POSTGRADUATE MEDICAL SCHOOL	D E V E L O P M E N T						
	P H A S E S						
	I	II	III	IV	V	VI	Totals
PROGRAM ELEMENT	(All in Net Square Feet)						
Learning Resources Center (Including Biomedical Library)	40,000					10,000	50,000
Drew School Administration and Dept. of Community Medicine	20,000					5,000	25,000
Instructional Facilities (Allied Health Sciences)		30,000					30,000
Child Care Center			30,000				30,000
Ambulatory Care Center				40,000			40,000
Continuing Education Center					15,000		15,000
Auditorium					7,000		7,000
Other Research Laboratories (Principally Basic Sciences)						55,000	55,000
Instructional Facilities (Undergraduate Medicine)						30,000	30,000
Services Unit	10,000					5,000	15,000
TOTAL - Each Phase	70,000	30,000	30,000	40,000	22,000	105,000	
TOTAL - All Phases							297,000

3.9 SITE DEVELOPMENT SYSTEM

The King-Drew complex presently occupies a site of 42 acres, of which 30 acres south of 120th Street (as relocated) are principally devoted to King Hospital and 12 acres north of this street are owned by the County and set aside for the Drew School. The consultants recommend: (1) that the balance of the land bounded by 120th Street on the south, Compton Avenue on the west, 118th Place and the extension of its right-of-way on the north, and Wilmington Avenue on the east, be acquired as a site for Drew facilities needed to house projected programs exclusive of undergraduate medical education; and (2) that this site be increased to 118th Street on the north to provide a campus to support expanded Drew programs beyond those now foreseen, and/or including undergraduate medical education. These site recommendations are illustrated on the following diagram.

The consultants propose, not a fixed site plan, but a flexible development system for Drew expansion. The principal determinants of the suggested system are: (1) the need to coordinate and integrate King-Drew facilities, making maximum use of shared facilities; (2) the necessity of providing a system in keeping with the modest scale of available or foreseeable resources; (3) the desirability of designing flexible, modular facilities able to respond to changing programs; (4) the provision of fixed circulation networks as a coordinating structure into which these flexible building increments can be plugged; (5) the attempt to reduce land acquisition, relocation, and clearance by encouraging development of a higher density campus. The recommended development system is illustrated on the subsequent diagram.

The indeterminate nature of the Drew program and adoption of such a system offer potentially significant savings in construction time and cost because they form a ready basis for fast-track programming, design and construction, systems building, and other contemporary techniques that promise more efficient space, more rapid construction, and more economical cost. The designation of its surroundings as an urban renewal area offers Drew an opportunity for site acquisition and coordinated neighborhood planning.

118th. ST.

118th. PL.

119th. ST.

120th. ST.

121st. ST.

118th. ST.

119th. ST.

120th. ST.

POTENTIAL ADDITIONAL SITE ACQUISITION FOR EXPANDED MEDICAL SCHOOL PROGRAMS

INITIAL SITE REQUIRED FOR THE CHARLES R. DREW POSTGRADUATE MEDICAL SCHOOL

EXISTING MARTIN LUTHER KING JR. GENERAL HOSPITAL

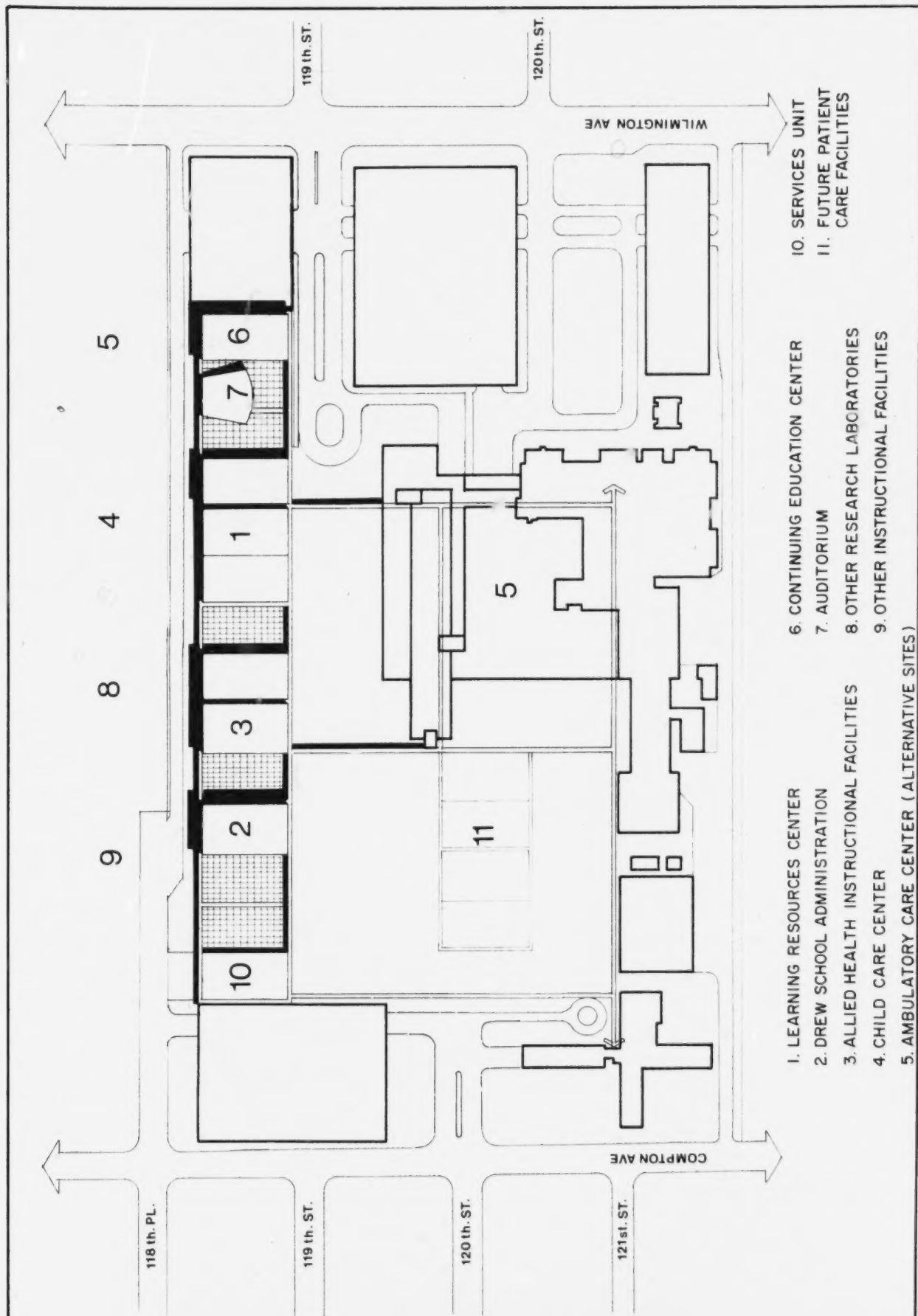
PROPOSED SITE:
CHILD CARE CENTER

A DEVELOPMENT SYSTEM FOR THE DREW SCHOOL

LESTER GORSLINE ASSOCIATES
PLANNING CONSULTANTS
TERRA LINDA, CALIFORNIA



5



A DEVELOPMENT SYSTEM FOR THE DREW SCHOOL

LESTER GORSLINE ASSOCIATES
PLANNING CONSULTANTS
TERRA LINDA, CALIFORNIA



3

3.10 CAPITAL EXPENDITURE

The following table projects the capital expenditures required for the building program outlined in Section 3.8. All costs are current costs, representative of Los Angeles area costs and are not escalated. Net square feet (usable area) are converted to gross square feet (total building area); representative costs per gross square foot are used to project building construction costs; these costs are multiplied by a factor to estimate project cost (including, in addition to construction costs, the costs of bonds, equipment, professional fees, contingencies, site work, etc.). The proportionate costs of undergraduate medical programs in the basic as well as the clinical sciences are clearly enormous.

The assumed development program could require ten or more years of virtually continuous construction. This is not the most economic building program and the cost/benefits of a long range program of relatively small increments versus a shorter program of comparatively larger increments warrants careful analysis. The choice is between the advantages of reduced escalation of project costs versus the disadvantages of earlier and larger financial commitments.

Financial survival has already been identified as the major issue facing Drew. Neither Drew nor any other medical school can expect in the near future the support of the federal joint construction grants that have been the traditional source of construction dollars for campus development. Drew's principal sources of funds remain: (1) Los Angeles County, (2) the State of California, and (3) the private sector. County participation would be encouraged by the unification of Drew and King and the consequent increased accountability of the County for the Drew School. State funding may be feasible if it does not entail undergraduate education in the basic sciences. The private sector will prove a worthwhile source of funds only to the extent that donors and foundations can be attracted whose interests are in long term, rather than short range, programs.

PHASE	PROGRAM ELEMENT	NSF	NET-TO-GROSS FACTOR	GSF	\$/GSF (1973 \$)	CONSTRUCTION COST	PROJECT FACTOR	PROJECT COST
I	LRC	40,000	1.6	64,000	\$48.00	\$3,072,000	1.35	\$4,147,000
	Admin. Unit	20,000	1.6	32,000	48.00	1,536,000	1.35	2,074,000
	Service Unit	10,000	1.4	14,000	48.00	672,000	1.35	907,000
	Subtotal:	70,000		110,000		\$5,280,000		\$7,128,000
II	Instr. Fac. (AHS)	30,000	1.6	48,000	\$55.00	\$2,640,000	1.35	\$3,564,000
	Subtotal:	30,000		48,000		\$2,640,000		\$3,564,000
III	Child Care Ctr.	30,000	1.8	54,000	\$48.000	\$2,592,000	1.35	\$3,499,000
	Subtotal:	30,000		54,000		\$2,592,000		\$3,499,000
IV	Amb. Care Ctr.	40,000	1.8	72,000	\$55.00	\$3,960,000	1.35	\$5,346,000
	Subtotal	40,000		72,000		\$3,960,000		\$5,346,000
V	Cont. Ed. Ctr.	15,000	1.6	24,000	\$48.00	\$1,152,000	1.35	\$1,555,000
	Auditorium	7,000	1.4	9,800	48.00	470,000	1.35	635,000
	Subtotal:	22,000		33,800		\$1,622,000		\$2,190,000
VI	Res. Labs (B.S.)	55,000	1.8	99,000	\$68.00	\$6,732,000	1.35	\$9,088,000
	Instr. Fac. (B.S.)	30,000	1.8	54,000	68.00	\$3,672,000	1.35	4,957,000
	Service Unit	5,000	1.4	7,000	48.00	336,000	1.35	454,000
	LRC (Add'n)	10,000	1.6	16,000	48.00	768,000	1.35	1,037,000
	Admin. Unit (Add'n)	5,000	1.6	8,000	48.00	384,000	1.35	518,000
	Subtotal:	105,000		184,000		\$11,892,000		\$16,054,000
TOTAL - ALL PHASES		297,000 NSF		501,800 GSF		\$27,986,000		\$37,781,000

PROJECTION OF CAPITAL COST ESTIMATES

SUMMARY REPORT - SECTION 4: THE PLANNING PROCESS

4. THE PLANNING PROCESS

Phase 1 of the Master Plan study was conducted from May 1971 to March 1972, and Phase 2 from March 1972 to March 1973. Both the general approaches and the specific methods of the two phases differed markedly, reflecting, in the later phase, a more positive approach to the problems of bringing together community residents with faculty and board members in planning for program development.

The work of Phase 1 was largely built around a series of twelve consultant-school conferences. These were designed not only as opportunities for the consultant team to report back to Drew, but were also conceived as opportunities for the participants to interact in a useful manner that, it was hoped would elicit new insights and new solutions.

At the same time, faculty and the administrative staffs of both Drew and King were interviewed. Attitudes and opinions were explored and information obtained about activities already undertaken or planned for the future. Among the more productive activities was the compilation of an inventory of programs under way or proposed by the various departments.

The most ambitious of the MPS team activities directed toward the community were four meetings held with representatives of various neighborhoods in the study area. The objectives of holding this series of "neighborhood panel" meetings were several. Familiarizing residents with the goals of the school, gaining some idea of the attitudes of residents toward the school, and identifying individuals who could speak for community interests and work jointly with the school in planning programs were among these. It was also hoped that some information on health care needs and community expectations of the Drew School could be gained from these gatherings.

The lessons learned from these "neighborhood panels" have been explored in detail in both the Phase 1 report and the main body of the present report. Briefly, the meetings were abandoned, probably prematurely, largely out of disappointment over their apparent lack of success. In retrospect, it became clear that much had in fact been learned even in atmospheres that sometimes generated more heat than light.

In addition to these activities, a principal effort of this phase was devoted to the gathering and analysis of health statistics and other data aimed at ascertaining the needs and existing conditions of the service area.

The work of Phase 2 began with a study of Drew's administrative organization, which was followed by a comprehensive questionnaire survey of the faculty, both to obtain in an orderly fashion information about faculty attitudes and to bring up to date the inventory of current and planned programs.

The principal work of Phase 2, however, grew out of the team's decision not to attempt to act as intermediaries with the community, as was done in Phase 1, but to provide vehicles for community participation in program development by organizing working groups made up of representatives from the community, King Hospital, and Drew School.

A steering committee was constituted in September; it, in turn, formed four task groups in the areas of drug abuse and alcoholism, maternal and child care, hypertension, and postgraduate training for health professionals. The overall process involved some 50 persons, of whom 25 were from the community. One lesson learned from this experience was that community participation worked best when the areas to be covered were clearly defined. As described earlier in this report, the effort of the steering committee and its task groups culminated in a series of program recommendations to the Board of Directors and which have been incorporated in the Master Plan.

A fifth group formed by the steering committee was a subcommittee that addressed itself to the problems of designing a health care delivery system for south-central Los Angeles. The work of this group led to a conclave of over 100 persons at a high school in January 1973. The conclave charged the subcommittee with continuing its work with a broader base of community participation.

As a consequence of the program planning effort, the consultants proceeded with estimates of required resources in terms of manpower, physical facilities, and funding. Of particular interest and importance in this field was the interest taken in Drew's planning by the National Library of Medicine and the National Medical Audiovisual Center. Two site visits were conducted by the NMAC director and his staff, contributing materially to the planning for the learning resources center.

In summing up the lessons learned, we note that the planning process was influenced by the fact that the Drew School is an emerging, not an existing, school. Where the study was most successful, it was often through a reversal of the traditional goal-oriented planning process (moving from universal statements of mission and philosophy to the particulars of programs, personnel, and resources). Greater success might have been achieved by following this process more consistently. Such a process might be generally described as first concentrating on a complete inventory of what is being done; moving from that to a summary of what is planned; comparing these to formulate complementary statements of problems and opportunities; abstracting from these statements the sense of mission and objectives they imply; ranking the resulting statements of problems and opportunities according to the real priorities allowed by available or expected resources; and, finally, projecting the resources required to satisfy these problems or take advantage of these opportunities.

ED 078795

Master Plan

for the Drew Postgraduate Medical School Los Angeles, California

To Bureau of Health Manpower Education, March 1973

Contract NIH 71-4149

Volume 2: Master Plan Report

**Lester Gorsline Associates
Arthur D. Little, Inc.
Urban Workshop**

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INTRODUCTION

This report is the culmination of a two-year effort directed toward the preparation of a Master Plan for the Charles R. Drew Postgraduate Medical School. The work was supported financially by the Commonwealth Fund and Bureau of Health Manpower Education of the National Institutes of Health (Contract NIH 71-4149).

The Master Plan Study Team which prepared this report was made up of representatives of three consulting firms, retained by the Drew School under a structure of subcontracts. The firms are Lester Gorsline Associates (Terra Linda, California), the Urban Workshop (Watts), and Arthur D. Little, Inc. (Cambridge, Massachusetts, and San Francisco).

The overall work was divided into two phases, Phase 1 being of a preliminary character, particularly in regard to the definition of programs and required resources. A document entitled MASTER PLAN STUDY: PHASE 1 PROGRESS REPORT was submitted to the Bureau in March 1972.

The present report, then, responds to the scope of work authorized in the contract for Phase 2, and is a plan for the development of the Drew School principally in terms of internal organization, program development, estimates of required physical facilities and capital funds, and site considerations.

The work could not have been carried out successfully without the active participation of many members of the Drew faculty and staff, the administration and staff of the Martin Luther King, Jr., General Hospital, and the residents of the surrounding community of south-central Los Angeles. Names of these contributors to the study will be found in Appendix 1.

I: The Historical Context

1. THE HISTORICAL CONTEXT

1.1 GROWTH OF THE DREW SCHOOL

The beginnings of the Drew Postgraduate Medical School go back to the Watts Riots of 1965. Prominent among the frustrations that were made public after that great upwelling of rage was the lack of health care facilities in the black ghetto of south-central Los Angeles.

Simultaneously with action to award Hill-Burton support to the Los Angeles County Department of Hospitals for the development of a "Watts Hospital," the concept of making this a teaching hospital emerged. A consortium was formed by the Drew Medical Society (Los Angeles chapter of the National Medical Association) and two medical schools, the University of Southern California and the University of California at Los Angeles, to create a new vital academic institution appropriate for the community and its needs. Both the "Watts Hospital" (which became first the Southeast General Hospital) and the Charles R. Drew Postgraduate Medical School were incorporated in 1966, a year after the Watts riots, and thus began a new adventure in medical education. The school is named for Charles Richard Drew, the distinguished black surgeon who established the first American Red Cross Blood Bank and whose research was instrumental in the expanded use of blood plasma during World War II. The Drew School is the academic partner of the Los Angeles County--Martin Luther King, Jr., General Hospital. The Drew faculty provides guidance and direction to the medical services in the hospital, supervises and teaches house staff, and holds a number of other responsibilities beyond those usually considered germane to "teaching hospitals" and "medical centers."

Each Drew School departmental chairman is chief of the corresponding clinical service in the hospital. Drew is affiliated with both the UCLA and USC medical schools. Each Drew faculty member carries a joint, concurrent appointment in one of the affiliated medical schools and has the same privileges, prerogatives, and obligations as their other faculty. The affiliation also obligates the medical schools to assist the Drew School with research facilities until its own laboratories are available, and to share in house staff recruitment for the opening year of the King Hospital.

The Drew School's unique characteristics reflect both perception and tenacity in working toward needed change:

First, its board of directors represents the full range of relevant interests, including both those of its sponsoring medical schools and medical society and those of several of the local communities and national groups ultimately affected by the school's capabilities.

Second, Drew is the first medical educational institution with such full orientation and commitment to community service, manifested by its responsibility for professional staffing of a major hospital, with emphasis on a department of Community Medicine which is planning a system of health services in concert with other community resources, and by its commitment to train persons from the community in the allied health professions.

Third, the school has been established in the midst of an urban ghetto which is overshadowed by memories of some of the worst civil strife in American history, and which still suffers from high unemployment and its consequent adversities.

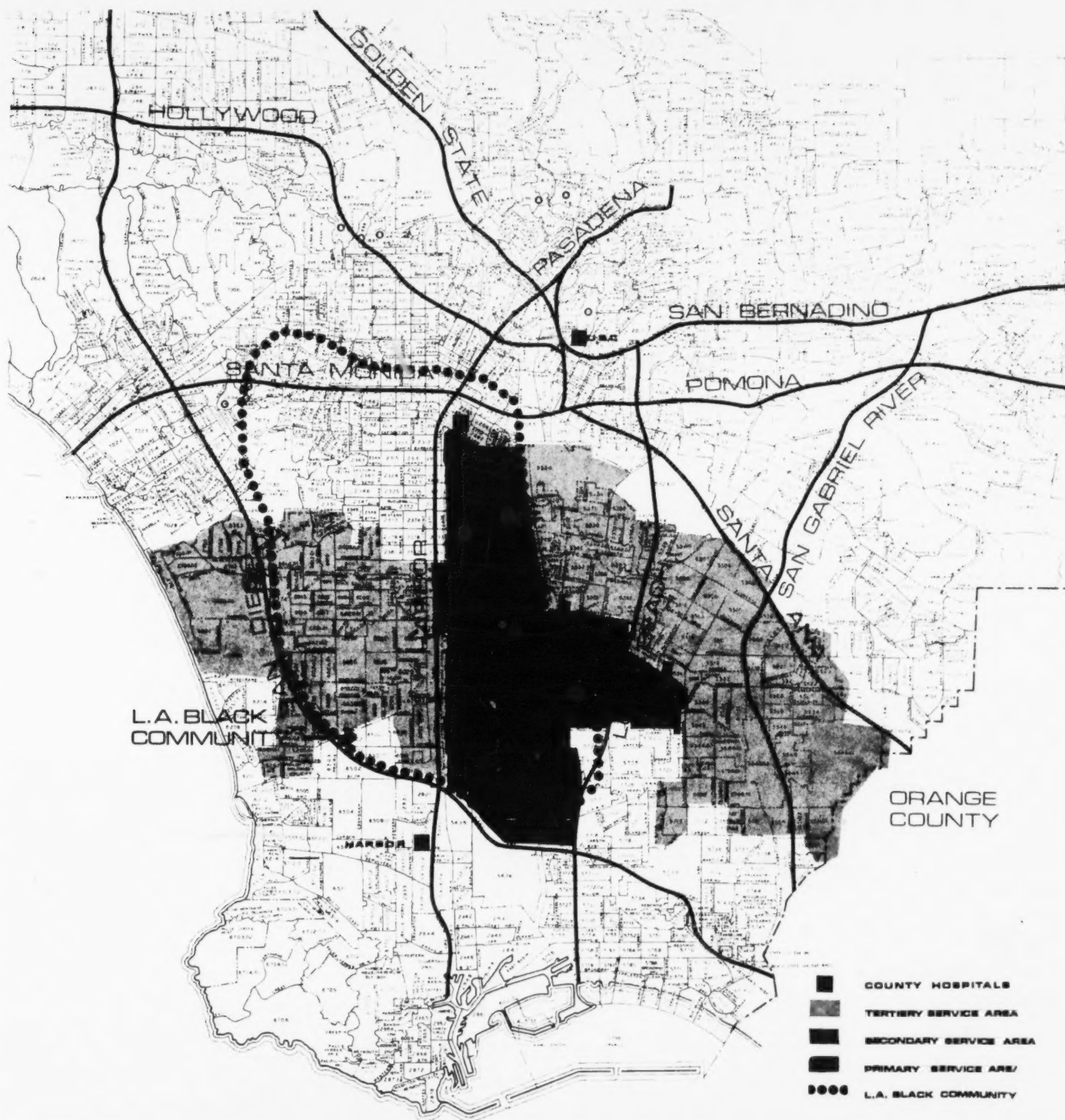
Finally, the Drew School, a nonprofit corporation, has established a complex network of relationships with governmental agencies, universities, and medical societies, and attempts to relate to a community in great need.

Financial support for the school was not easy to obtain. The Drew School concept did not fit nicely into the guidelines for most programs of federal support. However, the California Committee on Regional Medical Programs recognized the basic fact that the health status of people in the Watts-Willowbrook community, particularly their risk of heart disease, cancer, and stroke, could not be improved without a reformulation of the resources. It was seen that the Drew School, clinically oriented and situated in the community, could develop this needed organization of resources through community-focused health care, trained manpower, a teaching hospital, and programs and projects designed to build a rational health care delivery system.

On this basis, CCRMP approved the funding of three years' support to recruit a faculty and develop the school until the first unit of the King Hospital should become operational. The first RMP grant was awarded in 1968 jointly through RMP Areas IV (UCLA) and V (USC) to the Watts--Willowbrook RMP District Advisory Committee. Drew entered into an agreement with Los Angeles County similar to that between the County and UCLA for the professional services at Harbor General and with USC for the professional services at the USC-LA County Medical Center. The agreement was implemented July 1, 1971.

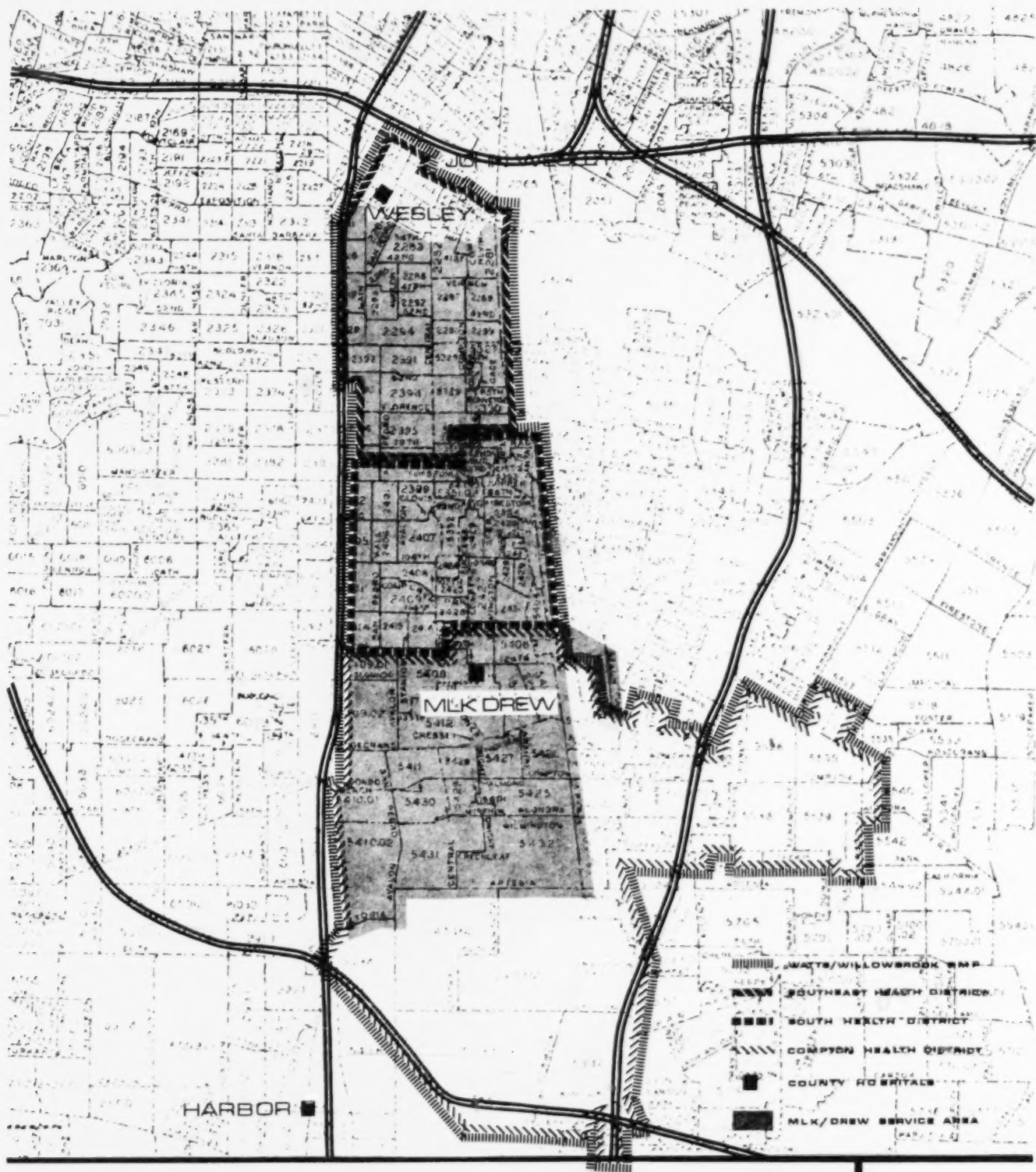
In the first RMP grant year, 1968-1969, the highest priority was to recruit a dean. A nationwide search led to the appointment of Mitchell W. Spellman, M.D., Ph.D., in November 1968. Dr. Spellman was a chief of surgery at the District of Columbia General Hospital and professor of surgery at Howard University College of Medicine. He had been a Commonwealth Fund fellow at the University of Minnesota, then returned to Howard as a Markle Scholar. Dr. Spellman came to the Drew School in January 1969.

Among Dean Spellman's first concerns was the development of a model



SOUTH L.A. COUNTY MLK/DREW SERVICE AREAS

CHARLES R. DREW
POST GRADUATE MEDICAL SCHOOL
MASTER PLAN PROJECT



HEALTH PLANNING AREAS

CHARLES R. DREW
POST GRADUATE MEDICAL SCHOOL
MASTER PLAN PROJECT

for the department of Community Medicine, one of ten departments in the school. A task force composed equally of community residents and scholars-administrators in the field proposed a plan which refocuses the traditional academic goals of education, patient care, and research. This effort was supported by funds from the Markle Foundation.

The plan defines community service as the school's paramount goal. Education, patient care, and research are to be conducted on this premise. The training of physicians in primary care medicine--including pediatricians and obstetricians as well as family practitioners--will assume particular importance in the King Hospital, since these physicians can be the core medical personnel for a total health care system both accessible and appropriate to a sprawling urban population.

The Board of Directors was soon expanded from the original seven members (two from each of the founding institutions and the Drew dean) to nineteen. Now, eight are from the immediate community and the Los Angeles area and three from the national community. Three are designated by the Drew Medical Society. The deans of the USC and UCLA schools of medicine serve, each with another member from the university. The dean of the Drew School is an ex officio member. The board of directors is the policy-making body of the school. Faculty positions, fiscal management, and facilities are among its concerns.

The geographic area to be served by the Drew School through the King Hospital is somewhat smaller than the Watts-Willowbrook RMP District, now Area IX, California RMP. It embraces south-central Los Angeles, Florence-Firestone, Watts, Willowbrook, and part of Compton. The Area IX, California RMP Advisory Council identifies health needs, formulates plans, and expedites projects for the RMP district, and an RMP core staff works on planning and communications with the community. Drew is the principal institution through which RMP plans can be implemented in the King service area.

Another agency important to Drew is the Southeast General Hospital Authority Commission, created by the county board of supervisors to sell bonds for facilities built on the King Hospital site. The commission is authorized to determine whether matching funds are to be raised by selling municipal bonds for the expansion of the hospital into a medical center. So far, it has authorized funds for building the acute unit of the King Hospital (464 beds), a community mental health center/mental retardation center* (76 beds increasing to 148 beds), a 216-unit residence for house staff (now under construction), a clinical research unit with initial laboratories for the Drew faculty, some structured parking, and an industrial laundry to serve three county hospitals. A health occupations training center for the teaching of allied health manpower has been discussed but has not yet been authorized.

* In April 1970, the California Health Planning Council awarded \$1.2 million of federal funds to the community mental health center and \$358,000 to the mental retardation center.

Foremost among the events of 1972 was the opening in March of the acute care unit of the King Hospital with the faculty of the Drew School comprising the clinical chiefs and full-time medical staff. (Problems raised by King's opening will be discussed in Section 1.4.)

A further development in physical terms was seen in the relocation, as planned, of 120th Street. As relocated, this street acts, in a general way, to divide the 42-acre site between those facilities that are primarily oriented toward King Hospital (30 acres) and those (12 acres north of the street) that will be primarily oriented toward the Drew School. (See Section 5.3.)

In the fall of 1972, as a result of needs expressed by the faculty and the administration, it was decided that the first building to be erected as part of Drew's long-range physical development plan should be a learning resources center which would also house the school's administrative offices. The National Medical Audiovisual Center and the National Library of Medicine made a commitment to assist in planning this facility. In December 1972 and January 1973, Dr. Charles Bridgman, director of the Center, and Messrs. Charles Farmer and Clement Benjamin of his staff conducted two site visits at Drew. (Their observations and advice are reflected in the description of the Learning Resources Center in Section 5.4.)

A significant event during the year was the first meeting at Drew of the board of visitors. Composed of seventeen members representing both the national and regional communities, the board of visitors was constituted to "provide counsel and assistance to the board of directors and Deans in pursuing the Drew School's mission as a regional and national resource." One result of the two-day site visit was the endorsement by the Board of visitors of the selection of a learning resources center as the first element of the physical development plan. (A list of members of the board of visitors will be found in Appendix 1.)

The past year also saw a proposed resolution of the question regarding the place that research will take in Drew's program. This resolution took the form of the preparation of a proposal for a multidepartmental biomedical research program oriented toward training students in the community in basic research techniques which was submitted for funding under the Minority Schools Biomedical Support program. (This proposal will be discussed in more detail later in this report.)

As a result of recommendations made by the Master Plan Study team in the spring of 1972, the position of director of Administration and Finance was created. John C. Fullmore, Jr., formerly Controller of Drew School, was appointed to the newly created post.

At the end of 1972, chairmen had been appointed to nine of the eleven departments. The two vacancies were in Family Medicine and Rehabilita-

tion Medicine. The chairmen were, in order of appointment:

M. Alfred Haynes, M.D., M.P.H., Community Medicine
Robert E. Greenberg, M.D., Pediatrics
John A. Campbell, M.D., Radiology
J. Alfred Cannon, M.D., Psychiatry
Ezra C. Davidson, Jr., M.D., Obstetrics-Gynecology
Joseph L. Alexander, M.D., Surgery
Valentino O. B. Mazzia, M.D., Anesthesiology
David D. Ulmer, M.D., Medicine
Elias Amador, M.D., Pathology

1.2 DREW'S COMMUNITY

In this section, we will briefly describe some of the salient social, economic, and health-related characteristics of Drew's immediate community, which is for our present purpose defined as that part of south-central Los Angeles which makes up the service area of the Martin Luther King, Jr., General Hospital.

Since the rebellion of 1965, an entire body of literature has been produced to describe the causes of that rebellion as well as the community in which it erupted. The purpose of this brief description is not to review or add to that literature, but rather to touch on specific characteristics of the community that bear on the purpose of this study and that can serve to highlight the magnitude of the community's problems.

About 340,000 people live within the present boundaries of the service area (hereafter called "the community") representing about 5% of the total population of Los Angeles County (hereafter called "the County"). About 83% of the community's population is black, as compared with 11% for the County; 12% are Spanish-speaking, compared to a little over 18% for the County. This leaves only about 5% of the community's residents from other origins (mainly white and Asian) compared to 71% in the County.

The boundaries of the service area are, however, scheduled for major expansion, bringing significant changes in the racial and socioeconomic characteristics of the population served. The change was initiated by the approval by the Los Angeles Board of Supervisors early in 1973 of a plan for the regionalization of health care by the Department of Health Services. The King Hospital administrative staff has determined that the population within a five-mile radius of the King-Drew campus will contain about 800,000 people, of whom 49.1% are black, 32.2% apparently white, 16.5% Mexican-American, 0.4% American Indian, and the remaining 1.8% Asian or from other ethnic backgrounds.

The present community also differs from the County in a slightly higher

proportion of females and in its relative youth. Females make up 52.9% of the community's population, compared to 51.6% for the County. The median age is 23, six years younger than the comparable figure for the County. The most striking contrast is found in the proportion of children between 5 and 19, who make up 35.5% of the community's residents, as against a figure of 27.1% for the County. (Statistical material here and in the following paragraphs was supplied by the department of Community Medicine.)

Low family incomes and a high unemployment rate are prominent characteristics of Drew's community. (It has been remarked, not entirely facetiously, that the greatest health need in the service area is jobs.) The median family income for the community is only \$5950, a little more than one-half the figure of \$10,970 for the County. The unemployment rate is 13%--more than twice the 6% rate for the County. Twenty-seven percent of community families live below the poverty level, as compared with 8% for the County, and 29% receive public assistance, again as compared with 8% for the County.

The ten leading causes of death in the community are, in order of importance, (1) heart disease, (2) cancer, (3) stroke, (4) accidents, (5) homicides, (6) cirrhosis of the liver, (7) influenza and pneumonia, (8) diseases of early infancy, (9) diabetes, and (10) circulatory diseases. The high incidence of accidents and homicides is particularly notable. The general level of health in the community falls far below that for the County, as evidenced by an infant mortality rate of 30.3 per 100,000 live births, in contrast to the Countywide figure of 17.6. A more pertinent measure of comparison has been provided by a study carried out by the department of Community Medicine which concluded that almost 1300 "excess deaths" a year occur in the King Hospital service area.

Some political and social characteristics of the community merit brief comment. Like many other natural communities in Los Angeles, the service area is not a political whole but falls within more than one jurisdiction--in this case the cities of Los Angeles and Compton and unincorporated areas governed by the Board of Supervisors of Los Angeles County.

The service area is a community of homes and stores, with comparatively little industry and few large-scale commercial establishments. By comparison with such a classic urban ghetto as Harlem, the low population density of the area brings some obvious advantages such as more playing space, more territory "owned" by a particular family unit, etc. These are to some extent offset by the long distances that must be traveled and the almost total absence of effective public transportation.

As will be noted in greater detail later in this report (Appendix 2) one of the major problems of the community is the drug traffic that exists on the streets and in the housing projects and reaches into the schools.

Before King Hospital opened in March 1972 the principal hospitals

serving community residents were Los Angeles General Hospital (in East Los Angeles) and Harbor General Hospital (in Torrance). Only five small private hospitals (the largest had only 127 beds) were located within this community of more than 300,000 people. About one hundred and forty physicians practice within the service area giving a physician-to-population ratio much lower than the national average, but by no means hopeless. Of these, 70% are in general practice. About half are black or of Spanish-speaking origin.

The community is not by any means homogenous in socioeconomic terms. It is, in fact, remarkably varied, with blocks of attractive and well-kept homes neighboring on areas of severely deteriorating housing.

Also on the positive side, we have observed that many of the community residents with whom we have worked show a considerable level of sophistication in coping with the representatives of public agencies and private institutions such as the Drew School. This sophistication has grown out of a history of involvement in community action organizations including neighborhood councils, welfare rights organizations, civic clubs, churches, and fraternal and labor organizations.

Clearly, Drew would be overwhelmed if it assumed responsibility for making a significant impact on all the major problems of its immediate community. Instead, its more effective roles are to provide leadership, example, and demonstration.

1.3 THE MASTER PLAN STUDY

In the spring of 1970, Drew School solicited proposals for assistance in planning the school's future from architectural and consulting firms across the country. A selection process was undertaken, involving presentations and interviews with many firms. The contract to undertake this work was eventually awarded to a consortium made up of Lester Gorsline Associates (Terra Linda, California), the Urban Workshop, Inc. (Watts), and Arthur D. Little, Inc. (Cambridge, Massachusetts).

The overall objective of the planning effort was to be a study setting forth recommended paths of development for Drew in terms of organizational structure, program development, and community relations, as well as in the more conventional master planning areas, such as resources allocation, site development, and a construction schedule. Consequently, the Master Plan Study speaks to somewhat broader issues than the usual architectural master plan.

The Master Plan Study was funded by the Commonwealth Fund and the Bureau of Health Manpower Education of the National Institutes of Health. The support of BHME (which entered the picture by making available funds

to match the \$100,000 planning grant offered by the Commonwealth Fund) resulted in two major influences on the conduct of the study.

First, the total effort was split into two phases, the first part of which was to be carried to the point of preliminary program development and preliminary estimates of required resources only, with the more definitive work in these areas scheduled for Phase 2. Secondly, the BEHE expressed its principal interest as being "the planning process by which an academic institution in an economically and socially disadvantaged area and members of the community can collaborate in health manpower education programs to raise the level of health in the community." This led to certain shifts of emphasis, with substantially greater effort being placed on community definition, description, and participation in the Phase 1 effort.

Phase 1 was concluded in March 1972, when its conclusions and recommendations were embodied in a progress report. The present document represents the "Master Plan for the Charles R. Drew Postgraduate Medical School" called for at the conclusion of Phase 2.

The basic questions which the Phase 1 study set out to answer were:

- (1) What are the limits of the "community?"
- (2) Who can speak for the community?
- (3) How can the community be brought into significant and continuous participation in planning Drew's activities?
- (4) What, specifically, does the community need that the Drew School can reasonably do something about?
- (5) How can these needs best be assessed?

Some of these questions were answered in the Phase 1 report; other answers were necessarily deferred to Phase 2. Briefly, the answers were:

- (1) The limits of Drew's community were determined to be the limits of the King Hospital's service area for patient care, but the boundaries of Drew's "community" were seen as extending to the region, the state and the nation.
- (2) The identification of community spokesmen remained a continuing problem during Phase 1. Little was accomplished in Phase 1, for it was soon made evident that the immediate community and the school were separated by a wide gap both in information and in attitude. In Phase 2, community people came forward as participants in the work of the steering committee's task groups. Furthermore, the department of Community Medicine developed a thousand-family sample with whom relationships would be established.
- (3) The most effective means of involving the community in Drew's

individual program planning was found to be the engagement of community residents around health activities of value to them personally, such as prenatal projects, foster-care projects, hypertension control, etc.

4. Drew's response to community needs were identified, also in Phase 2, as (1) raising the level of health in the service area, (2) humanizing the delivery of health care, and (3) providing opportunities for community residents to be trained in the allied health professions.
5. The best method of assessing community needs appears to be the encouragement of continuing interaction between the school and the community.

The Phase 1 study also revealed that, as faculty joined the Drew School, many departmental and some interdepartmental programs had been set in motion. The number of programs that were either already under way or in a planning stage indicated that the school's human and material resources were in danger of being rapidly diffused and dissipated if a school-wide review and priority-setting mechanism were not soon established.

The findings and recommendations made at the conclusion of Phase 1, which was completed only days before the King Hospital opened its doors to patients, reflect the experience of the Study, the intense pressure imposed on faculty to ready King Hospital, and inevitable encounters between persons determined to serve others of different socioeconomic background from themselves. The observations in Phase 1 point to administrative, planning, and relationship impediments which, if not recognized and corrected, could undermine the progress sought by Drew faculty and staff.

The Phase 1 report also drew attention to the "invisible" nature of the Drew School physically. The limited employment opportunities available to community residents were acknowledged as realities and handicaps. A most important observation was of the lack of control the Drew School can exert over the resources presently available to fulfill its mission. The school's financial dependence on a variety of funding agencies, each constrained by its own values and purposes, accentuates the absence of a distinct "power base" for the Drew School.

Preliminary space, building, and land projections were made during Phase 1 emphasizing the need for endowed professorships and a facility that would encompass faculty laboratories and offices, administrative services, animal facilities, a medical library and audiovisual center, and an auditorium. A tentative projection of \$20,833,000 capital funds was made in Phase 1, of which one-third was for endowed chairs. (These projections underwent substantial revision as more informed projections were made during Phase 2.)

This, then, was the point to which planning had progressed when the Phase 2 effort began in the spring of 1972. Although the same three-firm consortium proceeded with the Phase 2 effort, the focus of the effort shifted toward bringing together representatives of Drew and of the community in a structure of working groups charged with developing specific program proposals. Both the process and the outcome are described in later sections of this report.

1.4 AN OVERVIEW: ACCOMPLISHMENTS AND PROBLEMS

As it stands at present, the Drew School can point to many substantial accomplishments as well as to a full agenda of problems that call for solution. Among the more significant of these accomplishments and problems as we see them are the following.

1.4.1 Drew has recruited a capable and distinguished faculty.

Early in Drew's planning, the board of directors decided that senior faculty would be recruited on a nationwide basis rather than solely from the medical community of south-central Los Angeles. This decision has had repercussions that can still be felt and that have had both positive and negative impacts on Drew's growth. On the positive side, Drew has recruited a faculty that is made up of more than usually capable clinicians and educators, many of whom have years of professional growth and development ahead of them. On the negative side, we have been made aware that some elements in the community still feel that, since Drew exists primarily for the benefit of its surrounding community, its faculty should be drawn from largely the same community. This issue may, in time, be resolved as practitioners from the community are drawn into Drew's programs as part-time and voluntary faculty.

1.4.2 King Hospital has been opened and is operational.

The opening of King Hospital in March 1972 was in large measure made possible by the dedicated efforts of the Drew faculty--many of whom felt at that time that the opening was premature and risky. That elements of risk were not allowed to become explosive is a tribute to a devotion and professional skill of both the faculty and the hospital administration.

It must, however, be noted that relations between the King Hospital administration and staff and the Drew School personnel have not been entirely harmonious at all times. Some of the difficulties that have arisen certainly go back to what (in faculty minds at least) was seen as the premature opening of the hospital, with its consequent stresses and strains. Some, particularly among clerical and technical personnel, have their origins in the more flexible hiring practices at Drew, although

pay scales are identical with those of the hospital whose staff belongs to the County civil service. Some stem from operational difficulties during the hospital's shakedown period and have surfaced in the form of conflict and tension between the clinical chiefs and the hospital administration.

Given these not entirely unpredictable points of friction, it is gratifying to be able to report on the positive efforts that have been made by both sides to heal breaches when they become apparent. One such effort was a series of retreats for Drew and King people. A major outcome of the October 1972 retreat was the establishment of a joint King-Drew Medical Center committee to settle issues as they arise and before they are allowed to become corrosive.

1.4.3 A wide variety of programs has been mounted by the various departments.

It is typical of the growth of a new medical school that the development of intramural and extramural programs generally takes place on a departmental rather than an institutional basis. Drew is no exception. A year ago, at the time of the Phase I progress report, some 60-odd programs had been set in motion or were planned by the departments. Some of the proposed programs are now under way; other new programs have been proposed.

These programs fall into the following general categories: (1) residency training programs in each department; (2) programs directed toward training health workers at various levels (e.g., nurse anesthetists, x-ray technicians, physicians' assistants); (3) continuing education for community physicians; and (4) educational programs directed toward community residents in general (e.g., family life education, drug and alcohol abuse education, hypertension education). (See Section 3 for a complete list of Drew's programs.)

1.4.4 Institutional programs have been identified and agreed upon.

Within the past six months, program planning has begun to proceed on an institutional rather than a departmental basis. The impetus for institutional program planning has come from two directions: (1) the preparation by the Drew administration and faculty of an application for funds to support an institution-wide biomedical research program and (2) the organization, with the help and guidance of the Master Plan Study team, of a steering committee to consider the range of programs which Drew might undertake and to recommend specific programs for adoption. An initial grant of \$100,000 has been made by the Kaiser Family Foundation to support young investigators, and which complements the biomedical research program. The program planning effort will be described in detail in Section 3.

1.4.5 Relations with the south-central Los Angeles community have, on the whole, improved.

It was recognized early in the Master Plan Study that the relations between Drew and the residents of the surrounding community represented a central and critical issue in the development of the school. Our perception of the present state of Drew-community relations is that there is considerably less misunderstanding and hostility than there was a year ago. Part of this improvement is surely due to the exercise of a spirit of accommodation and forbearance by the principal participants on both sides. Part is due to the continued participation in policy-making of community representatives on the board of directors and the involvement of community residents in program planning through the Master Plan Steering Committee and its task groups.

Closer contact between the school and the community has also been achieved through the participation of Drew faculty and administrators, together with community people, at a weekend convocation designed to discuss the outlines of a health care delivery system for the service area. (See Section 3.2.)

1.4.6 The development of the faculty of Allied Health Sciences has run into difficulties.

During the past year, a planning contract with the BHME was completed and submitted. It outlines a model of an operating consortium of educational and training institutions focused on allied health manpower. During the brief tenure of an acting dean, Faculty of Allied Health Sciences, a permanent dean was sought. Dr. John Mitchell was approved for the post in March 1973. Continued federal funding of allied health manpower programs placed the future of this faculty, its institutional form and progress, in further constraint.

1.4.7 The mechanism of leadership is not well balanced.

At present, leadership at the Drew School is exercised through the board of directors, the office of the dean, and faculty (primarily the department chairmen). Although the present arrangement has served moderately well during the period of Drew's development, we believe that a better balance needs to be achieved among the board, the dean, and the faculty. The board should be free of matters involving practical detail in order to deal with policy. The administration needs to deal more with internal integration and less with acting as the faculty's advocate to the board. The faculty must be more responsive to the board and administration and less concerned with independent program development within the departments. In Section 4 of this report we will outline a scheme of organization which calls for a strengthening of the executive functions of the dean's office. In accord with this recommended organizational structure, a director of administration and finance has already been appointed, and the creation of the post of director of planning and development is one of the recommendations of this study.

2: Mission and Strategies

2. MISSION AND STRATEGIES

2.1 THE MISSION

Given its actions, statements of intent and institutional development to date, the central mission of the Drew School is to raise the level of health in the Martin Luther King, Jr., General Hospital service area. That is why Drew is located where it is; that is why it was founded in the first place; and that is the yardstick by which it will be judged. This mission is the common bond which joins the Drew School and Martin Luther King Hospital. It is what can link both of those institutions to other health resources in the service area.

There seems to be little basic disagreement about this central mission. Drew's faculty has exemplified this commitment by devoting itself largely to delivering care in the MLK Hospital. The department of Community Medicine, the only department which does not deliver patient-care service in the hospital, has compiled data on the service area and has mounted educational programs for paramedical personnel to produce health professionals, some of whom can add to the local roster of health manpower. Laboratory research at the school has been accorded a low priority so far, and the major Drew proposal to NIH for biomedical research incorporates the training of local high school and college students in the conduct of research as a major theme, thus placing research in the context of education and community service.

The number of community physicians and community residents on the Board of Directors is an unusual and most significant expression of the school's sense of responsibility to its community.

Many public statements have been made by the dean and other members of Drew's faculty and staff that have reinforced Drew's primary commitment to community service. These statements are summed up in the report of the Ad Hoc Committee on Appointments and Promotions, dated August 11, 1972, which contains the following relevant passage:

The Drew School was founded to serve the health needs of a community through a comprehensive system of clinical services, educational programs and research activities. This direct relationship between a medical faculty and existential health realities is the axis on which everything turns; it is our Archimédéan lever for addressing a seemingly overwhelming burden of diseases and disabilities in a community, our lodestone for planting the content of educational curricula and fertile soil for relevant research.

The results of a survey of the faculty and staff conducted by the Master Plan Study consulting team are highly supportive of the same theme. The overwhelming majority agreed that Drew should "respond first to the needs of the local King-Drew service area, bearing in mind, but not being governed by, the applicability of programs to a broader 'national constituency.'"

A greater diversity of opinion was revealed in response to a question about the reason for Drew's existence. Half the respondents indicated that Drew's first priority was to upgrade the general level of health in the community. Thirty-five per cent indicated their view that the first priority was to deliver health and health educational services to the King-Drew service area.

Thus, while there is by no means unanimity among the faculty and professional staff on Drew's priorities, it is important to emphasize general concurrence on Drew's central mission, because it has tended to be obscured by the many disagreements over means of accomplishing that mission. Too often, what are really strategies have been taken for goals. Clarification of this distinction can help the faculty now to make better decisions about programs, staffing, and growth. It can help the administration to make better decisions about the allocation of administrative time and energy. It can help the Board of Directors to discern better which issues are important enough for it to address. It can help community leaders and residents to understand Drew's actions and to relate more directly to the school. Finally, it can help other medical schools to form appropriate linkages with Drew as a resource for them and their students, and to understand the pressure Drew may exert on them to place students from the service area in their programs.

Among other goals that have been suggested is that of improving the local economy by providing jobs and opportunities for training. While Drew should certainly strive to contribute to the economic betterment of the service area, this cannot be the central reason for its existence. Drew has relatively few jobs to give out. Most of the funds which flow through Drew go to meet specific contractual or grant obligations connected with patient care, education, or research activities. Consequently, Drew can have only a marginal impact on the economy of the service area.

In a somewhat similar vein, Drew cannot be, centrally, a community action agency. To be sure, Drew should seek ways of involving community leaders and residents to a much greater extent than is customary for most other academic medical institutions. Moreover, it can choose to adopt community involvement as a means for improving health levels. But its central mission concerns health, not political action.

Finally, while some faculty members will want to devote a significant part of their efforts to laboratory-based biomedical research, Drew cannot devote as much of its effort to such research as is customary in

academic medical centers. Few of the people attracted to Drew seem to have research as a central preoccupation, and there is little, if any, support inside Drew or from outside funding agencies or from the community for research as a central theme.

To be sure, research can have an important role at Drew. It can enable experience to be organized in a way which produces maximum learning. It can attract funds. It can be a powerful tool in assessing the effectiveness of various methods of delivering health care. But research--whether basic research or research oriented to the patient or to the community--cannot be the organizing theme for Drew as an institution.

There are other accountabilities beyond the immediate King-Drew service area. These include a responsibility to HEW and other government agencies that supply funds, to the whole of the Area IX Regional Medical Program, and to the Board of Supervisors of Los Angeles County.

Yet, it is in the immediate King-Drew service area that Drew must discover its own ways of being accountable and responsible. Most other academic medical centers view themselves as being "in" (geographically located in) but not part of the community. They pay their "dues" for local occupancy and for the opportunity to draw on the community as a source of patients used for teaching purposes, but they regard themselves primarily accountable to state and/or regional constituencies in the case of many state schools, and to a national constituency in the case of many of the private schools. Drew, on the other hand, is "of" the service area, not just resident in it. It has taken on a special responsibility to raise the level of health in this community. It has the opportunity to work with the community in determining what this responsibility means and how best to meet it.

A major task which has been undertaken by the department of Community Medicine is to develop ways of measuring the level of health in the community and assessing changes in the level of health over time. Beyond this, Drew will need to come to an increasingly comprehensive view of what "health" means by expanding the definition of health well beyond "the absence of disease," and by devising processes for assessing its own impact on the level of health, however defined.

2.2 STRATEGIES FOR IMPLEMENTATION

There is less agreement on the strategies to accomplish Drew's mission than there is on the mission itself. This is to be expected; all organizations composed of intelligent, forceful people face the same problem of choice of strategies. A continuing task for Drew's administration, faculty, and board will be to discover areas of common ground where

movement can happen, where conflicts can be worked out and where situations can be redefined so that positive action becomes possible.

This is no easy job, given the differing aspirations of faculty members, board members, community leaders and residents, and representatives of other medical schools, each of whom has his own kinds of interests focused to some extent on Drew, and for each of whom certain goals have some claim to special priority. The faculty is concerned with using discipline-based skills, building departments, maintaining freedom and flexibility, delivering care, and producing research results. Board members are concerned with representing their various constituencies--universities, funding sources, the medical society, and community groups. Community leaders are concerned with obtaining economic betterment, more humane and compassionate health care delivery, and enough power with respect to Drew to influence its plans, programs, and hiring practices. UCLA and USC see the King-Drew complex as a setting for valuable clinical experiences for their students. Local physicians are interested in obtaining continuing education and in gaining access as respected colleagues to the acute care beds of the MLK Hospital. Finally, the hospital is concerned with delivering treatment and claiming enough of the time of the Drew faculty to be able to meet its commitments.

These differing perspectives and aspirations can be reconciled by a wise and careful choice of strategies to accomplish Drew's mission without needlessly consuming resources that are necessarily limited.

2.2.1 Improving Relations with the people of the King Drew service area

If Drew is to succeed in raising the level of health in the King-Drew service area, it must continually strive to know the service area better--its problems, aspirations, demography, history, key people, organizations, and needs.

As has been emphasized in virtually every description of the Drew School, Drew stands in a relation to its surrounding community that is different from the relationship obtaining at other medical schools in the country. A number of factors, both positive and negative, must be considered in assessing the quality of Drew's current relationship with the people and organizations of the King-Drew service area. On the positive side, the membership of the Drew School Board of Directors includes representatives of the local community and local physicians. Community residents participate on selection committees and advisory bodies. High school students are enrolled in a laboratory enrichment program. For women of child-bearing age, family planning and educational services are available.

On the negative side, community leaders interviewed during the course of the Master Plan Study report little contact with or understanding of Drew and its activities. The local physicians are reported to be

apathetic regarding Drew. There has been frequent conflict between members of Drew's administration and faculty and certain community factions, particularly regarding the development and staffing of the faculty of Allied Health Sciences. A petition was circulated by one of these factions which demanded certain actions of the Drew School with respect to the ombudsman, the dean of the faculty of Allied Health Sciences and other issues. As a consequence the county supervisors held up their contract with the Drew School for several weeks in 1972. Frequent confrontations between community residents and Drew people have occurred at open meetings of the Board of Directors and other forums.

There are too many factions, too many interests, too many divergent goals to permit easy resolution of Drew's problems in relating to the local community. But, steps can be taken immediately to build more comprehensive community relationships, not simply as being a desirable action in itself, but to put the institution in closer touch with enough parts of the community so that it is fully aware of both the health needs of the community and the resources with which it can link to do something about those needs.

There appears to be ample faculty support for enriching Drew-community relationships. When asked in the faculty survey what Drew should start doing that it is not doing, many faculty members replied that Drew should expand its relationships with the community by making more contact with community organizations, community action programs, social and fraternal organizations, and religious groups. Some specific suggestions advanced in this survey and in interviews with members of the board and the community are as follows:

Secure more active involvement of local physicians on the faculty of the Drew School, in its councils, and on the staff of the MLK Hospital. One specific point is that more Drew faculty members should attend meetings of the attending staff. Recruiting efforts, especially with local general practitioners, will need to be stepped up.

Continue and expand community involvement in Drew's program planning and development, following the model of the Steering Committee and task groups that was developed and used in the Master Plan Study to involve community leaders in Drew's planning. Similarly, the community-oriented mechanisms set in motion by the department of Community Medicine in designing a health care delivery system should serve as a point of departure for a continuing effort in this direction.

Take steps to increase contact with community leaders such as ministers, heads of community action programs, business leaders, educators, political figures, and heads of municipal and county services--listening to them, informing them of Drew's activities, and discovering areas of possible mutual support. Drew should also increase its participation

in community activities such as agency meetings, coordinating councils, neighborhood councils, and community meetings, as an active contributor and learner.

Full-time appointment is, of course, only one mechanism. Voluntary and part-time association in school programs--particularly in continuing professional education and consumer education--can substantially increase local professional participation. We urge Drew to define clearly the part to be played by local physicians, including the setting of targets in terms of the numbers of such physicians to be recruited in the various categories.

Developing programs in the near future to work with the "helping agencies" in the community, such as the police, fire department, and social service agencies--training them to be aware of health problems they will encounter and enabling them to meet health crises in a more comprehensive way.

Greater recognition of the contributions community people make through their involvement in Drew. This is especially important in the make-up of brochures, press releases, and other statements for public consumption. There are board members particularly sensitive to this issue who can be contacted immediately for assistance in this area.

Closer involvement with local high schools and community colleges, building on existing programs in the departments of Pediatrics and Obstetrics.

Establishment now of a school-wide newsletter to the community, building on the expertise developed already in the department of Community Medicine.

Establishment of a speakers bureau.

Through Drew's contacts with UCLA and USC, channeling of students from the service area to those institutions, pressing for scholarship support where needed.

Develop a "curriculum" for community residents on how to deal more effectively with health care professionals, with health care organizations and institutions, and with the politics and economics of health. This undertaking would entail some risk, but it also represents a creative, innovative strategy to achieve Drew's mission.

Drew has provided technical assistance to the development of some legitimate prepaid group practices in the local community; regrettably, other entrepreneurial interests, taking advantage of HMO incentives, have also sprung up. Drew acts as a watchdog and tries to assist consumers

in determining whether a plan is capable of providing quality health care. But the concept of stimulating legitimate, quality prepaid practices remains valid.

By providing training programs for health care administrators and planners, Drew could enable the community to develop faster by supplying people who can manage organization.

Drew could also actively promote the development of independent enterprises needed in connection with a medical center--transportation services, day care, answering services, laundry services, drug stores, etc. If Drew does not get involved from the outset, it may wind up as a disappointed bystander.

Such actions will be taken only if Drew's administration and faculty view closer relationships with the community as a high-priority strategy for achieving the school's central mission. Implementing this strategy more forcefully at the outset will largely be the responsibility of the Dean, directly and through his Director of Planning and Development. (See Section 4 for a description of the proposed functions of this new office.)

The board is also a powerful force in relating Drew to the local community. The board is not a closed corporation composed of hand-picked insiders and easily led by the administration, as so many institutional boards tend to be. Moreover, much of the real power to make decisions, set policy, and provide direction resides in the board, more so than with most other academic medical institutions, where the preponderance of power resides with the faculty. Drew's board members, collectively, know a great deal about medicine, health care, and how the institution functions. Moreover, the board collectively knows a lot about this community, either directly or through contacts of board members. The board can thus exert much influence over the make-up of joint faculty-community program development efforts, how programs are shaped to relate to community needs, and the degree to which Drew's administration and faculty will give priority to community relationships.

In relating to the community, Drew will probably have to take much of the initiative. Community physicians, for example, seem to have adopted very much of a wait-and-see posture, which can be seen in their apparent lack of interest in joining the staff of the MLK Hospital and in the long time it has taken to form the Attending Staff Association. Perhaps it partly indicates apathy or a reluctance to reduce commitments to private practice, but perhaps it also reflects a disbelief on the part of community physicians that they would really be accorded colleague-ship with the Drew faculty. In either case, if Drew wants community physicians to become involved, it cannot afford to wait for them to assert their interest.

Similarly, community residents, however vocal some individuals are,

cannot be expected to sustain relationships with Drew without an active effort on Drew's part. Despite what might be inferred from the heat generated at public meetings, Drew is not a full-time preoccupation with community people. It is up to Drew to develop the necessary vehicles for sustaining relationships and also to be willing to meet the community on its terms, at its meetings, as a participant.

2.2.2 Education and Training

Drew is an educational institution. It is not in the patient care business, though its faculty delivers health care in the hospital. The King Hospital is the institution responsible for delivering patient care in an acute setting, while community physicians and allied health professionals deliver care in the community. As for research at Drew, it is viewed in the contexts of both education and service.

Drew can employ education and training to improve the level of health in the community in two ways: it can train health care professionals and administrators, upgrading their skills and helping residents of the service area to enter the health professions; and it can educate consumers to be better able to take care of themselves, to make choices about when to come in contact with the health care resources in the area, and to use these resources more effectively.

The primary question is determining the mix of educational activities which most benefits the community in terms of improved health and which is of sufficient interest to retain a well-qualified faculty.

Drew is training or plans to train a number of different types of students:

Post-doctoral trainees in the various clinical disciplines (house staff at the King Hospital). The house staff of the King Hospital (interns and residents) now number 74. This number is projected to increase to 128 in July 1973 and to about 200 in July 1974.

Community physicians and other health professionals. Physicians, dentists, nurses, social workers, technicians, and other allied health personnel will benefit from continuing education and/or additional certification.

Allied health professionals. Physician assistant training programs are functioning now at the Drew School with over 40 students, about half of whom are from minority groups. Additional programs are being planned in the allied health professions, and the intent is to establish a separate faculty in allied health.

Students in other educational institutions. A pilot program for

training high school students in biomedical sciences and research is currently under way at Centennial High School with 20 students. This program is funded by the Model Neighborhood program and employs both high school and Drew faculty. The proposal for biomedical research recently submitted by Drew expands on this concept by proposing the training of an additional 20-30 students from the local service area in programs of biomedical research.

These programs are aimed mainly at training health care professionals or preparing people to enter the health professions. Drew can also choose to develop training programs for health administrators and health planners. (The department of Community Medicine plans to establish a residency in community medicine which will include training in administration and planning.)

The developers of professional education programs at Drew are--or should be--thinking in terms of objectives and ways of measuring progress toward those objectives. Progress in this direction was encouraged by the appointment in September 1972 of a director of continuing professional education.

The second major educational focus, consumer education, is emerging as a major prospective activity for Drew, one which can have a substantial payoff in terms of preventive medicine, the effective use of health care resources, and the creation of a more self-sufficient community.

Many of the health and health-related problems in the service area can be attacked in part through consumer education. These include drug abuse, venereal disease, infectious diseases, nutritional problems, hypertension, maternal and child care, and family development. Programs in consumer education can have other advantages as well. Consumer education can bring Drew's faculty closer to the community through direct contact with community residents. The use of community-based resources such as schools, churches, and homes can also serve to expand Drew's relationship with the community. Consumer education helps to build a health care system by informing people of the health resources available to them. It provides evidence of direct, demonstrable benefits from the existence of Drew. Consumer education can be very cost-effective, reaching many people with a fairly small use of resources. Consumer education allows ample room for innovations in the use of media and settings. Finally, and of great importance, consumer education programs provide ample opportunity to involve community residents in the design of those programs.

There is growing recognition in the Drew faculty of the importance of consumer education. In the faculty survey, basic health education for local residents was the most often cited need in the service area, with a total of 38 mentions as compared to 32 for the area next in priority, training in the health professions for area residents.

Dean Spellman's testimony to the Dymally Committee reads in part:

The first six months' experience in the MLK Hospital suggests that greater health education [for consumers] could alter patterns of broken appointments, misconceptions about diagnostic tests, and other negative responses to seeking needed health care. The patient process of assisting community residents to enhance their understanding of the methods of entry into the health service network--and the acceptance of substantial personal responsibility for self-care--may be the most responsive and responsible function we can perform beyond trying to heal the sick who present themselves when disease is obvious and advanced. The more disease and disability are prevented in this community, in which 40,000 person-years are lost due to premature death each year, the more measurable our improvements in health status.

In the program development process of the Master Plan Study (described in more detail in Sections 3 and 6 of this report) the key areas of hypertension, drug abuse and alcoholism, and maternal and child care, which were singled out for priority development by Drew, all contain a substantial consumer education component.

By developing comprehensive programs in this area, we feel that the Drew School can make a major contribution. In our view, consumer education represents a key strategy toward improving the level of health in the community.

2.2.3 Undergraduate Medical Education

Since Drew's inception, the question of undergraduate medical education has been an issue. Recently, with the advent of the Dymally subcommittee and its hearings into the prospect of Drew's establishing an undergraduate program, funded by the State, the need to respond to the issue has become more pressing.

As Senator Mervyn M. Dymally, chairman of the subcommittee, wrote to Dean Spellman in September 1972, "One of the major tasks of the subcommittee is to study the advisability and feasibility of expansion of the existing Charles R. Drew Postgraduate Medical School to include undergraduate education; and determine to what extent the Martin Luther King, Jr. hospital can be utilized in the future development of Drew."

As Dean Spellman concluded his testimony before the Dymally subcommittee on October 30, 1972, "We can agree, I believe, that medical schools are conceived as social institutions and should be secured and strengthened by public policy which reflects this conviction. We propose that the State of California consider support of Drew School on the basis of this judgment. The institutional mission will thereby be sustained and opportunities for the fulfillment of its promise will be better assured."

The Drew board of directors has gone on record in favor of an undergraduate program, as noted in the dean's statement, and it represents a potential source of State support for Drew. The interest expressed by a subcommittee of the State legislature has reached the point of discussing operational and programmatic funding, with State support being based on the expansion of Drew into undergraduate medical education.

We recommend strongly that if Drew decides to mount a program of undergraduate medical education it should be limited to clinical education, with the students' preclinical work being accomplished elsewhere.

A clinical teaching program could be organized in two steps. First, the King-Drew campus could serve as a "clinical campus" for medical students from USC and UCLA. In the second step, Drew would assume the entire responsibility for organizing and administering a clinical curriculum for students of its own.

In view of the reassessment of medical education that is going on now at many schools throughout the country, it would be entirely appropriate for the Drew School to undertake a study aimed at developing a new pattern of medical education. This new pattern might take the form of organizing an integrated premedical and basic science curriculum at a consortium of colleges in the area. Upon completion, for example, of a five-year integrated preclinical course leading to a master's degree, the student would then enroll for the clinical component of his curriculum, to be administered by the Drew School, taught by Drew's faculty, and located in King Hospital, the projected Ambulatory Care Center, and any other patient care facilities associated with the Drew School. The M.D. degree would be granted by the Drew School.

In any case, for the foreseeable future, an undergraduate medical education program at Drew would be reasonable only if it did not interfere with the accomplishment of more urgent objectives.

2.2.4 Humanizing Health Care

It is not enough for Drew to produce technically competent health professionals. Those professionals must also be able to relate to patients and have some understanding of their life circumstances.

When much of the angry rhetoric of community residents is stripped away, what is revealed is their profound sense of being treated as objects by professionals who are ostensibly helping them. Examples cited during the Master Plan Study include: long waits in general hospitals, unneeded surgery, brusque treatment by overloaded physicians, courses of therapy prescribed which are impossible to carry out. This same problem is echoed many times when community residents come in contact with the police, social service agency workers, educators, and government bureaucrats. Drew cannot do much outside the realm of health care, but it can do some-

thing with the professionals it trains, by encouraging them to develop their basic human capabilities so that their technical competence will be matched by a sensitivity to the fears and anxieties of their patients.

People who suspect or know that they are being treated as organ systems or as objects by those who are supposed to be helping them in moments of great physical and psychological stress are justifiably angry. This anger may be the source of energy for much of the challenge to Drew as an institution, and the wellspring of much mistrust. We believe that it also explains why some (though by no means all) community representatives feel that Drew should be all black--that only blacks have even the potential of understanding and identifying with community people sufficiently to be responsive to their needs. (As we have noted elsewhere, however, the County regionalization plan will markedly reduce the proportion of black residents in the area to be served by the King-Drew complex.) The need for humanistic health care and the demand that health professionals be trained to be more sensitive to patients have been strong themes at community meetings. In a recent meeting of the Agency Executive Advisory Committee of South Central Los Angeles, comprising the leaders of most of the area's social service agencies, a plea was strongly made to Dean Spellman that workers in the hospital be better trained to deal on a person-to-person basis with drug addicts, and that Drew train doctors to be more conscious of human situations such as the circumstances from which patients come and to which they will return after therapy. It was one of the major themes expressed by community residents at the conclave held January 27, 1973, to initiate planning for an improved health care delivery system for the service area. This sentiment was echoed during the interviews with several community physicians, who judged that they and their colleagues had become lax in their duty both to develop a more compassionate relationship with patients and to develop a more comprehensive approach to what they were doing.

The task force on postgraduate education of the Master Plan Study Steering Committee strongly recommended that Drew humanize health services by increasing the emphasis on equity of health care delivery, improving the individual's ability to participate actively in his own course of treatment, and recognizing the cultural differences which exist in the service area. The Ad Hoc Committee on Promotions and Appointments said in its August 11, 1972, report that "although technical education is important, certain nonacademic experiences are significant in conditioning the manner in which health professionals apply their skills to the solution of human problems. Experiences of this type which are relevant to the Drew mission include living and working with economically deprived or minority peoples." The dean, in his testimony before the Dymally subcommittee, said, "Our house officers, we believe, are learning how to consider the whole social fabric of a patient's situation, not just to deal with the damaged organ or psyche."

Some people question whether these sensitivities can be taught. It is

not easy to re-educate people whose basic attitudes have been well established by the time they come in contact with Drew. But we feel that if this aspect of training is given high priority both in the design and development of curricula and in the recruitment of faculty and students, improvement can be made.

Following are some specific methods which can be employed:

Discovering physicians in the community who seem to have particularly helpful relationships with their patients and encouraging those physicians to be preceptors or teachers.

Joint problem-solving with community residents around specific health issues.

Encouraging students to develop personal contacts in the community.

Seminars and exercises where role-playing is an important component.

Admitting trainees to the hospital as patients.

Learning in community settings.

Enabling trainees to work in multidisciplinary health care teams.

Sensitivity or encounter training.

These ideas by no means exhaust the possibilities. They are meant to be evocative and illustrative, and to indicate that processes do exist for sensitizing professionals to the people they seek to help.

While advocates of an orientation toward more humanistic medicine base their views on a variety of premises, to us perhaps the most compelling rationale is that increased sensitivity means better medicine. It means more accurate diagnosis and more appropriate treatment. It means having a patient who is more able to carry out a therapeutic regimen prescribed by the physician. Finally, it means more effective collaboration between Drew and its community in identifying and solving health problems.

2.2.5 Faculty Recruitment and Creation of an Intellectually Rich Environment

The recruitment of a highly qualified faculty has been a key strategy to date in building the school. Table 1 indicates where the faculty has come from over the past four years. For the time being, substantially all of the key faculty has been recruited, but the process will not stop. There will be turnover and some more growth in faculty. A more explicit strategy needs to be developed to deal with faculty recruitment in the future.

Table 1

PREVIOUS AFFILIATION OF FACULTY

DEPARTMENT CHAIRMEN

New York University College of Medicine
National Medical Association Foundation & Johns Hopkins University
School of Hygiene and Public Health
Harvard Medical School
Columbia University College of Physicians and Surgeons
Case Western Reserve University School of Medicine
Stanford University School of Medicine
University of California-Los Angeles School of Medicine
Indiana University School of Medicine
Walter Reed Army Medical Center

ASSOCIATE PROFESSORS

Kaiser Foundation Hospital, Sacramento
Medical Director, South Central Multipurpose Health Services Center
University of Southern California School of Medicine
Temple University
Private Practice of Internal Medicine (gastroenterology)
Clinical Staff, Los Angeles County-USC Medical Center
Childrens Hospital of Los Angeles
Cedars of Lebanon Hospital
USC School of Medicine
Private Practice-Oral Surgery, Orange, California
Private Group Practice, Providence Hospital, Ft. St. John, British
Columbia, Canada
University of Pennsylvania School of Medicine
University of Southern California School of Medicine
University of Iowa College of Dentistry
South Central Multipurpose Health Services Center
Los Angeles County-USC Medical Center
City of Hope

ASSISTANT PROFESSORS

UCLA School of Dentistry
City of Hope Medical Center
University of Southern California School of Medicine
Long Beach Veterans Administration Hospital
University of California Service, San Francisco General Hospital
Orange County Medical Center

Table 1 (continued)

ASSISTANT PROFESSORS (continued)

Cedars-Sinai Medical Center
University of Southern California at Los Angeles
University of Washington School of Medicine
California Pediatric Center
Henry Ford Hospital, Detroit
Johns Hopkins University School of Medicine
Ohio State University
University of California Los Angeles
Napa State Hospital, Napa, California
Los Angeles County-USC Medical Center
Temple University Health Sciences Center
Indiana University School of Medicine
UCLA School of Medicine
Stanford University School of Medicine
Holy Family Hospital, Lutsao, Chia-Yi, Taiwan
Army General Hospital, Frankfurt, Germany
Provident Hospital, Baltimore
Orange County Medical Center

CLINICAL ASSOCIATES

New York University Medical Center
Los Angeles County-USC Medical Center

developed to deal with faculty recruitment in the future.

Much of the conflict swirling around Drew has involved faculty recruitment. There has been considerable pressure on Drew to recruit faculty locally. Community physicians and others in the resident population interviewed during the Master Plan Study said they were greatly disturbed by the number of faculty members who have been recruited from outside of the service area and the region. Since the Drew School was founded as a response to the needs of this community, the origin of the faculty is a matter of some importance.

At a minimum, local physicians are a vital resource of information to keep Drew in touch with the needs of the community. But more than that, they have much to teach academic physicians about the realities of delivering care in this service area. If Drew is going to link academic medicine to the realities of the service area, then community-based health professionals are a key part of the link.

The internal environment of Drew is and will be a major determinant of the types of faculty attracted, of who stays and who leaves, and of whether community physicians find it worthwhile to associate with Drew. Accordingly, careful attention needs to be paid to this aspect of Drew's development, particularly since Drew lacks some of the usual incentives which draw people into medical academic settings. For example, Drew has no endowed chairs which can provide financial and organizational security to faculty members. It does not have, nor will it probably have, a large laboratory-based biomedical research program supported by outside sources of funds and capable of productively employing large numbers of physicians and researchers. Neither is Drew intending to build a faculty which carries on a substantial private practice to supplement their salaries. Drew does not yet have the kind of institutional prestige which is gained through a long history of operation and which in turn would enable it to serve as a springboard for physicians wishing to rise in academic medical circles.

Some of the things Drew is doing or can do to attract and hold the creative and community-oriented faculty members it needs include:

Increasing the range of settings in which to teach--physicians' offices, neighborhood health centers, local schools, other hospitals--to give both teachers and students exposure to different learning situations and opportunities to discover new ways to learn.

Enabling those faculty members who want to, to engage in activities outside their particular specialties and to interact constructively with people from other disciplines by providing opportunities to shift from department to department relatively easily, by involving the faculty member in institution-wide planning activities, and by forming cross-disciplinary activities addressed to specific health care needs.

Involving the faculty in the search for new approaches to health care delivery by establishing an ongoing program of research in this area, which is generally recognized as one of the most challenging problems in medicine today.

Enabling faculty members to come in contact with a wide variety of students, ranging from consumers of health care to postdoctoral fellows.

2.2.6 Developing an Improved Health Care Delivery System for the Service Area

Both the faculty and the Master Plan Steering Committee regard this need as a major priority for the Drew School. The subcommittee established by the Master Plan Study Steering Committee to look into an improved health care delivery system quickly discovered that while models were easy to construct on paper, actual implementation of the systems was something else. (The complete report of this subcommittee will be found in Appendix 2. In summary, the subcommittee recognized that most elements in a health care delivery system were outside of Drew's control but saw an opportunity for Drew to act as a catalyst or facilitator in developing a process to bring about an improved system.) Drew has now taken the first step, with the active support of the department of Community Medicine. A conclave was designed to assess the needs of those who will be the key participants in any system, regardless of configuration--consumers, providers, people from the King-Drew complex, and representatives of financial intermediaries. The conclave, held on January 27, 1973, attracted some 100 persons. Follow-on meetings are planned to the end of developing an improved health care delivery system tailored to the needs of the service area.

Given the increasing importance of ambulatory care, family medicine, and preventive medicine, the health care system should include the creation of a network of community health centers, administratively linked to the King-Drew complex and operating in close conjunction with local physicians. These centers can also serve as important settings for the education and training of health professionals and allied health students.

2.2.7 Optimizing the King-Drew Combination

The Martin Luther King, Jr., General Hospital is obviously a major vehicle for achieving Drew's goal of raising the level of health in the community. Drew's faculty operates largely in and through the King Hospital, delivering patient care in its acute care setting. It is inconceivable that work in the King Hospital will cease to be a major activity of the majority of Drew's clinical faculty. Moreover, the training of King house staff is one of Drew's major commitments.

One of the original reasons why Drew was established was to ensure the delivery of quality care in the King Hospital. Without Drew, King's academic affiliation would probably be with UCLA or USC, and it was felt by Drew's founders that neither of these institutions outside the community was the appropriate affiliation for an institution born out of the riots of 1965. One of the original hopes for Drew was that it would provide access to the King Hospital for community physicians and responsiveness to community residents, so that the hospital would not become a closed, impersonal institution, perceived by people in the community as being unresponsive to the people and needs of the service area.

In order to maximize the combination of Drew and King, both institutions will need progressively to clarify the handling of those areas where they overlap and to define the areas in which each operates outside the sphere of immediate interest of the other. Administratively, they will need to develop mechanisms to shift funds from one institution to the other where one uses space in the other, where support personnel are used and paid jointly, where medical information and computer systems are shared, where Drew needs to supervise activities maintained for the hospital, and where greater efficiency is possible through sharing as in a joint library.

A King-Drew Medical Center Committee has been established whose membership includes the King Hospital administrator, the dean of the Drew School, the Medical Director and director of Nursing of the King Hospital, the chairman of the Drew Board of Directors, and other representatives of the two institutions. Ultimately, this committee, or a derivative of it, may be called upon to handle these administrative matters. We recommend, in Section 4, that a long-range goal of Drew and King be the establishment of a joint governing board, although we recognize that this cannot be brought about without major changes in the present administrative and legal framework.

The strategic task is one of increasing clarification and agreement in order to minimize duplication and areas of potential conflict. Operationally, it means systematically sharing plans and working out the details of joint activities. For the time being, the best available mechanism for doing so is the King-Drew Medical Center Committee, supported by the chief fiscal officers of each institution.

2.2.8 Collaborating to Increase Capabilities for Institutional Response

Our social institutions are increasingly being called to account by communities, political structures, and funding sources. The institution as a whole, not the individual department, is held accountable. What happens in one part of the institution affects the rest.

Also, health problems are increasingly being defined in ways which are

not amenable to solution by any one medical specialty. This is particularly true in areas such as drug abuse and the need for more comprehensive systems of health care delivery. The need for inter-disciplinary and interdepartmental collaboration in medical institutions is increasingly being recognized as desirable and even as crucial to institutional survival.

President Stephen Muller of Johns Hopkins University put the issues clearly in his Daniel Coit Gilman Lecture in November of 1972. What he had to say is applicable in the Drew context:

We are now in a position where we have to reexamine the internal administrative structure by which we have grown great. We must not destroy it, but make it more useful and more flexible. I am referring to the basic unit of the American higher education and of American academic medicine--the department. There are two things about the departments at Johns Hopkins that are quite striking. They are desperately overloaded as administrative units, and they are organized traditionally along vertical lines and disciplines. They have fragmented into subspecialties. I don't think anyone needs to make the point any longer that we need what every institution like us needs now: interdisciplinary effort.

It is terribly important for busy and brilliant people to work with institutional arrangements that facilitate rather than obstruct what is important. The purely departmental structure is in many ways too much of an obstacle. We must find ways to make it as easy as possible administratively for people to work together, and I believe that interdisciplinary efforts can be effectively woven into the existing departmental structure. I would not ever wish to see the departments go, because I have seen nothing that works as well even when they are not working as well as we would like them to work. What I am suggesting is a two-ply approach which allows departmental structures to be married to interdisciplinary units--we call them centers here.

The situation at the Drew School is, if anything, more complicated than that at Johns Hopkins. Even though Drew does not have the long Hopkins history and entrenched power centers, it does have another actively involved party--the community.

Drew has taken some active steps toward building interdepartmental coalitions. Pediatrics is collaborating extensively with Obstetrics in the development of the maternal and infant care project; Psychiatry and Pediatrics provide adolescent care; and all three contribute to prenatal care and the handling of postpartum depression and psychosis. Community Medicine involves the departments of Medicine, Pediatrics, and Psychiatry in the training of its Medex program. Radiology interacts with Surgery,

Medicine, Pediatrics, and other hospital-based operations in supplying services, as does Pathology. A variety of other areas represent potential opportunities for one department to collaborate with others, as indicated in Table 2.

During the Master Plan Study, collaboration has developed in the process of initiating a health care delivery system for the service area and in program planning in the four high-priority areas chosen by the Master Plan Study Steering Committee. (The committee's decisions on programs are described in Section 3.)

To have maximum effect on the level of health in the service area and to deal flexibly and responsively with situations as they arise, Drew needs to make collaborative efforts an integral part of its operation. The Ad Hoc Committee on Appointments of Faculty spoke to this issue by saying that "the Drew mission demands a mutually supportive faculty to mount clinical task force endeavors on a community-wide basis." The Task Group on Postgraduate Education for Health Professionals recommended that "there must be a working out of ways for individuals, departments, and/or programs to come together" in the Drew School.

The problem with interdisciplinary collaboration is that people agree with it as a nice concept, but little is usually done to press actively for it. Grants and contracts are department-based and departments constitute the only really functional units in the Drew School beside the Office of the Dean. Thus, the strategy for Drew should not be to eliminate departments or radically reorganize the school, but rather, as President Muller of Johns Hopkins indicated, to develop ways of making it easier and more profitable for departments to work together.

Since the recommendations in this report for improving interdisciplinary responsiveness are of an organizational character, they are discussed in more detail in Section 4. Briefly they include the following:

- Establishing a position of director of planning and development,

- Immediately establishing a school-wide program review committee,

- Establishing a Drew project accounting mechanism,

- For large endeavors, such as the Child Care Center, establishing a separate administrative unit along the lines of an institute, reporting directly to the dean,

- Making institutional funds available to encourage development of interdisciplinary endeavors, and

- Making it easy for interdepartmental shifts of people to take place on a temporary basis.

TABLE 2

AREAS OF PROSPECTIVE COLLABORATION

(Departments listed in the left-hand column indicated possible areas of collaboration with departments arrayed along the top of the table.)

TO COLLABORATE WITH

Mentioned by:	ALLIED HEALTH	ANESTHESIOLOGY	COMMUNITY MEDICINE	MEDICINE	OBSTETRICS-GYNECOLOGY	PATHOLOGY	PEDIATRICS	RADIOLOGY	PSYCHIATRY	SURGERY
ALLIED HEALTH		-Training, medical programs -Recruitment	-Same	-Same	-Same	-Same	-Same	-Same	-Same	-Same
ANESTHESIOLOGY					-Scheduling operations					-Scheduling operations
COMMUNITY MEDICINE	-Developing medical manpower -Involving Chicanos -Recruitment of students -Providing backup in formation for projects -Health education	-Providing backup in formation for projects -Development of family practice -Health education		-Residency program in family practice -Providing backup information for projects -Health education	-Maternal child care project -Providing backup in formation for projects -Development of family practice -Health education	-Providing backup in formation for projects -Health education	-Environmental hazards to children -Day care services in the community -Providing backup in formation for projects -Development of family practice -Health education	-Providing backup information for projects -Health education	-Services for senior citizens -Providing backup information for projects -Development of family practice -Health education	-Trauma registry -Providing backup information for projects -Health education
MEDICINE	-Training of allied health professionals -Educational approaches to management of stroke, hypertension, heart disease	-Link with community resources -Referral for continuing care -Education programs for patients -Education cooperation of community physicians			-Genetic counseling -Fertility and in-fertility -Hypertension -V.D.	-Alcohol and drug abuse -Hypertension -V.D. -Diabetes	-Genetic counseling -Metabolic disorders -Diabetes	-Hypertension	-Alcohol and drug abuse -Hypertension -V.D.	-Hypertension
OBSTETRICS-GYNECOLOGY		-Program development in maternal and infant care, maternal and child health education					-Program development in maternal and infant care, maternal and child health education -Prenatal service and training			

TABLE 2 (continued)

← TO COLLABORATE WITH →										
	ALLIED HEALTH	ANESTHESIOLOGY	COMMUNITY MEDICINE	MEDICINE	OBSTETRICS- GYNECOLOGY	PATHOLOGY	PEDIATRICS	RADIOLOGY	PSYCHIATRY	SURGERY
Mentioned by:										
PATHOLOGY	-Medical technology program		-Sickle cell program -Continuing education				-Sickle cell program	-Radio-immune assays		
PEDIATRICS			-Sickle cell disease -Health planning		-Perinatology -Fetal medicine -Maternal and infant care				-Drug abuse -Child development -Mental retardation	-Combined case management
RADIOLOGY	-Institute training programs									
PSYCHIATRY	-Training programs		-Development of self-help groups		-Prenatal development of child -Adolescent prenatal care -Postpartum depression and psychosis		-Child development -Learning disabilities -Special adolescent problems -Child abuse and neglect -Drug abuse and alcoholism	-Dealing with patients		-Consultation and in-service training
SURGERY			-Trauma program -Cooperative cancer treatment program -Patient follow-up	-Congenital cardiac anomalies -Cooperative cancer treatment program	-Outpatient surgical clinic for minor surgical procedures	-Congenital cardiac anomalies -Cooperative cancer treatment program	-Congenital cardiac anomalies -Trauma program -Early diagnosis and treatment of pediatric orthopedic problems	-Congenital cardiac anomalies -Trauma program -Cooperative cancer treatment program		

The development of further linkages between departments can significantly strengthen Drew as an institution, making it possible to discover areas of work which are foreclosed to the individual department. More constructive relationships can be developed with community groups, permitting the institution to respond to needs in the local service area which may not be of high priority to any one unit in the organization but which are of high priority to the institution as a whole.

3: Program Development

3. PROGRAM DEVELOPMENT AT DREW

3.1 THE ROLE OF PROGRAM DEVELOPMENT

Programs are organized and planned sets of activities aimed at achieving explicit objectives and supported by funds specifically earmarked to carry out the activities. Programs in education, research, and service delivery are the ways in which Drew expresses itself as an institution. They organize the energies of people to produce tangible results, which in turn can be evaluated for their effectiveness.

Some of the specific benefits which result from the process of planning programs and from actually conducting them should be to:

1. Organize resources--of time, energy, and dollars.
2. Define relevant work--make clear what specific tasks need to be done to accomplish a given set of objectives.
3. Set measurable goals--establish yardsticks by which progress is measured.
4. Obtain funds--from outside sources, both to accomplish the objectives of the project and to provide for overhead expenses to cover the administrative activities of the Drew School.
5. Achieve interdisciplinary collaboration--bring people from different backgrounds and different disciplines together to achieve something which no one discipline can do alone.
6. Learn from experience--through periodic reviews evaluate experience to date and modify future activities in light of that experience.
7. Deliver a valuable product--a service that is traceable to the existence of the program and validates the time and effort spent by the people involved.
8. Involve the community--in program development, implementation, and review.
9. Express Drew's priorities in concrete action--demonstrate priorities in more effective ways than words provide.

The work done in the course of planning a program and developing a proposal provides its own framework for:

1. Making choices about how to spend time before resources have

been committed.

2. Developing and testing priorities which reflect Drew's goals and, in the process, help to refine those goals.
3. Discovering who needs to be involved in developing and conducting a particular program by explicitly thinking about the makeup of the program team.
4. Developing innovative approaches to problems to obtain funding, to attract people who are already busy, and to differentiate the work of a particular program from other activities.
5. Estimating manpower and space requirements.

Careful attention to the above factors in the design and implementation of programs can benefit both the beneficiaries of the program and Drew.

3.2 PROGRAM DEVELOPMENT DURING THE MASTER PLAN STUDY

The process of program development under the Master Plan Study was begun in late summer of 1972. It was directed toward two major objectives. The first was to stimulate positive institutional processes (i.e., clarify Drew's goals, gain greater interdepartmental collaboration and wider community participation, test a new mechanism for program development, and make everyone more aware of the programmatic activities existing and possible in Drew). The second was to formulate program objectives which could result in concrete action to benefit the community in areas either where Drew has not been active before or which are presently being developed on a departmental level but need wider institutional support.

The Master Plan Study program development process was intended to supplement the program activity already under way at Drew, not to replace it. There are a sizable number of such programs at Drew, based for the most part in the various departments. These are summarized in this section.

The Master Plan program development process, rather than simply compiling a list of existing departmental programs, took a fresh approach to identifying program priorities for Drew as an institution. This was based on two considerations: (1) the needs of the service area as seen by the faculty, as revealed by data on mortality and morbidity, and as articulated by community practitioners and residents; and (2) the institutional priorities and responsibilities of the Drew School.

The programs sketched out by the Master Plan Study will draw on department-based manpower and energy, acknowledging the fact that Drew is organized along departmental lines. The process also identified program areas where it was not at all obvious that a particular department should take

the leadership, yet where it was clear that Drew as an institution must do something. For example, there is considerable faculty support for the strategy of developing an improved health care delivery system for the King-Drew service area. Achieving this requires the collaboration of many departments as well as of providers, consumers, and financial intermediaries who are not part of Drew. Similarly, it is important that Drew mount programs in drug abuse and postgraduate training for health professionals, though no one department is capable of doing the whole job and none of the departments may consider these as top priorities in terms of its own growth and development.

The program development effort undertaken during the Master Plan Study established a steering committee, composed of faculty and board members and the top administration of MLK and Drew. Each of the members of the steering committee was carefully chosen (appointed or elected) by a process which gave the committee as a whole legitimacy and authority for getting the work done. The steering committee reviewed a faculty survey taken earlier by the consultant teams and selected the following areas for further development based on the results of that survey.

1. The development of an improved health care delivery system for the King-Drew service area.
2. Initial planning of programs in drug abuse and alcoholism, maternal and child care, hypertension, and postgraduate training for health professionals.

Each of the above areas represents a need in the local community; each has the potential for high visibility and direct impact on the level of health in the King-Drew service area.

The Steering Committee then appointed several separate task groups to address these individual program areas in detail. These task groups included community residents and local health care professionals as well as Drew faculty and MLK personnel. The process involved a total of some 55 persons prior to a conclave on health care delivery systems held on January 27, 1973. A comprehensive description of the program development process is contained in Section 6.

Ideally, development of an improved health care delivery system should precede work on specific health problems, since an improved system would facilitate work on these problems. However, the development process is inevitably long and complicated, requiring the voluntary commitment of different kinds of people with differing concerns--consumers, private practitioners, members of the King-Drew complex, financial intermediaries, County Health Department personnel, and allied health workers. In the meantime, something must be done about the high-priority health needs of the service area. Thus, work on these program areas was undertaken simultaneously with work on the development of a health care delivery system.

Several of the specific programs identified in the four high-priority areas were already under way, particularly in the departments of Pediatrics, Obstetrics, and Medicine, dealing with maternal and child care and hypertension. The program development process served to endorse these activities as being central to the near-term objectives of the Drew School. In other cases, particularly in the area of drug abuse, new programs had to be identified. In the area of postgraduate education for health professionals, the most urgent need was seen as the coordination of present and prospective programs.

In most of the areas chosen, implementing programs will require collaboration of a high order among various disciplines in Drew. In drug abuse, for example, many departments should be involved--Psychiatry, Medicine, Pediatrics, Obstetrics, Pathology, and Community Medicine, to name the key ones.

The following recommendations for specific program development were made by the subcommittee on health care delivery systems and the task groups and were endorsed by the steering committee. (See Appendix 2 for the full texts).

1. Health Care Delivery System

After considering general goals and objectives, the group recommended that the next step should be to explore the specific objectives of a health care delivery system with providers, funding agency representatives, consumers, and representatives of the King-Drew complex. The January convocation described elsewhere in this report (Section 6) responded to this recommendation.

2. Postgraduate Training for Health Professionals

The task group submitted three recommendations: (1) for a maximum of joint planning on both the interdepartmental and interinstitutional level; (2) for a definition of the spheres of influence in present and future training activities within the King-Drew complex; (3) for "constant, aggressive and active attention" to involve the community physician in the full growth and development of all aspects of the King-Drew complex.

3. Hypertension

The task force recommended that the Drew School provide a broad base of support for two programs planned by the department of Medicine: (1) training community health workers in hypertension case finding and follow-up; and, (2) training nurse practitioners in control and treatment of hypertension. It further recommended that Drew mount a general educational program aimed at making residents of the community aware of the dangers of hypertension and its consequences. A fourth recommendation was that in planning its learning resources center,

Drew provide an information system that would provide physicians and other health professionals in the community with useful and timely data with regard to hypertension.

4. Maternal and Child Health Development

This task group identified seven programs for priority development: (1) a child care center; (2) family life education; (3) school, health, and learning disabilities; (4) teenage health education; (5) reaching adolescents through working with gangs; (6) research and development in maternal and child care; and (7) fetal intensive care systems.

5. Drug Abuse and Alcoholism

The task group recommended that Drew should: (1) develop drug and alcohol abuse education programs aimed at users and potential users, parents and educators, law enforcement officials, physicians, and political leaders; (2) develop alternative activities such as youth development, employment opportunities, parental support counseling services and halfway houses but not become involved in methadone maintenance; (3) develop a mechanism to coordinate ongoing activities; (4) establish a detoxification program in King Hospital; and (5) conduct research in alternatives to existing treatment and educational programs.

The Master Plan process took program development to the point where objectives and priorities were sketched out. Actual steps have been taken to design and implement an improved health care delivery system for the King-Drew service area. The steering committee recommendations were sent to the Board of Directors for review.

The next steps we recommend are:

- (1) Reconvening (and perhaps some reconstituting of) the various task groups.
- (2) Identifying key faculty members who can pull together teams and spearhead the development of specific proposals to funding agencies.
- (3) Pinpointing which funding sources to approach.
- (4) Developing specific proposals.

Drawing on the work of the steering committee and its task forces and on the programs being conducted and planned by the various departments, we recommend the following general areas for high priority attention in program development activities:

Consumer health education

Allied health professions education

Continuing education for local health care professionals

Health care delivery system development and implementation

This listing is not intended to imply a 1-2-3-etc., priority ranking, but rather our recommendation that Drew intensify its efforts in these areas simultaneously.

We believe that these areas represent the greatest opportunity for making a contribution where beneficial results can be attained most immediately. We do not believe that the area of undergraduate medical education offers the same opportunities for short term impact and it has the significant disadvantage of requiring great capital and operating expenditures. We have excluded the residency programs from the above high priority category, largely because they are almost all presently in the operational stage. The resources we have projected in Section 5 of this report reflect the above recommendations of high priority areas for program development.

Where the basic goals, priorities, and strategies of the institution are at issue, it is up to the institution's board and administration to pull people from different disciplines to organize programs, providing institutional support in terms of dollars and expertise to insure that programs are, in fact, implemented. There are various organizational means for carrying out such broad scope programs. Most medical schools have faced this problem and devised different approaches to it at one time or another. The research or patient care "institute" is one example of an organization frequently used to carry out multidisciplinary programs.

In the case of some of Drew's proposed activities, such as the child care center or the ambulatory care center, one way to organize may be for the dean (with the concurrence of the department chairmen) to appoint a "project director," who would be responsible for pulling together the required team. Time and money spent in organizing the project could be arranged through a special "Drew project account" and paid out of institutional funds. The project director should work closely with the director of planning and development who could provide administrative, technical, and other support.

Drew is a functioning institution. It has a history, its people are organized along departmental lines, and a variety of devices can be used to begin projects which are Drew School projects, cutting across those departmental lines. The primary criterion is to find simple ways that can be dismantled after the project is finished. The project director approach seems to us to meet these criteria.

3.3 DEPARTMENT-BASED PROGRAM DEVELOPMENT

While the Master Plan Program Development effort concentrated on institution-wide priorities, considerable program development activity has been and is taking place in each of the departments at Drew. The following tables, developed from information supplied by the department chairmen, summarize that activity. Table 3 describes programs already under way. Table 4 describes programs which are in the proposal stage, but not yet funded. Table 5 discusses projects and programs being seriously considered but not yet at the formal proposal stage.

TABLE 3
PROGRAMS/PROJECTS UNDER WAY

Title/Name	Purpose	Target Population (if any)	Approximate Amount of Funding	Source of Funding	Starting Date	Duration	Name of Program Director	Comments
<u>ANESTHESIOLOGY</u>								
1. Nurse Anesthetist Training	60 trainees (30 per class)		\$400,000/year	L.A. County	2/8/72	Indefinite		
<u>COMMUNITY MEDICINE</u>								
1. Continuing Education	Provide program of continuing education for physicians, nurses, dentists, pharmacists	Health professionals in King Hospital service area		RMP	9/1/71	3 years	Duane Dillman, Ph.D.	
2. Health Care Administration	To increase level of understanding of the community in health related programs; to continue joint planning with the community and to help in the coordination of comprehensive health planning; to work with consumers and providers to achieve coordination and systematization of health care services	All persons residing in King service area	\$830,776/yr. (direct costs)	RMP	9/1/71	3 years	Myrtle U. Caton, MD	Involves community organizers, health planners, health educators, social scientists, environmentalists
3. MEDEX I	Train 19 physician assistants	Trainees and preceptors mainly from King service area	\$702,351 (direct costs)	HSMHA HEW	7/1/70	2-1/2 yrs.	M. Alfred Haynes, MD	Involves Medicine, Pediatrics, Psychiatry, Emergency, physicians, educators, administrators, clerical
4. MEDEX II - Physician Assistant Training Program	Train 20 PA's	"	\$212,156 (direct costs)	BHME HEW	6/30/72	1 year	M. Alfred Haynes, MD	"
5. Functional Task Analysis (FTA)	To study in depth how patients receive ambulatory health services from health care personnel	Health personnel and patients in ambulatory care centers under study	\$499,704 (direct costs)	BHME HEW	6/19/72	2 years	M. Alfred Haynes, MD	Involves research analysts, EDP programmers, data clerks

TABLE 3

PROGRAMS/PROJECTS UNDER WAY

Title/Name	Purpose	Target Population (if any)	Approximate Amount of Funding	Source of Funding	Starting Date	Duration	Name of Program Director	Comments
COMMUNITY MEDICINE (continued)								
6. Neighborhood Health Center Evaluation	Evaluate neighborhood health centers		\$277,832 (direct costs)	OEO	6/14/72	2 years	L.S. Wu, Acting Director	Involves medical record librarians, physicians, social worker, statistician
7. MLK Hospital	To develop a department of Family Practice, King-Drew Medical Center; to assist in the development of health care programs in the hospital and to assure that the services are acceptable to the public	Hospital staff and persons in King service area	\$140,000	L.A. County	March 1972		M. Alfred Haynes, MD	Involves physicians, dentists, health educator, clerical
MEDICINE								
None								
OBSTETRICS/GYNECOLOGY								
1. Residency Training	24	Graduate physicians	\$400,000	L.A. County	7/1/71	4 years	E. Davidson, Jr., MD	Involves departments of Pediatrics, Anesthesiology, Medicine and Pathology
2. Maternal & Infant Care Project (MIC)	Comprehensive maternal health	Pregnant women, South	\$600,000	HEW through L.A. County MLK professional staff association	7/1/72	3-5 years		
3. Family Planning	Comprehensive family planning service	All females 15-45 years of age	\$160,000/yr. (direct costs)	LAFPC	7/1/71	Indefinite	E. Davidson, Jr., MD	6 sessions per week involving MD's, admin., clerical, and technical people
4. Maternal & Child Health Education	Comprehensive patient education for mothers	MLK service area		L.A. County		Indefinite	M. Seravalli	Involves Pediatrics, Psychiatry, Community Medicine, Social Service, Dietary, Nursing, Community Volunteers

TABLE 3
(cont.)
PROGRAMS/PROJECTS UNDER WAY

Title/Case	Purpose	Target Population (if any)	Approximate Amount of Funding	Source of Funding	Starting Date	Duration	Name of Program Director	Comments
OBSTETRICS/GYNECOLOGY (continued)								
	Community leader Workshop to acquaint community leaders and their groups about important issues relating to maternal and child health and available services	Community leaders	\$1300/year	National Foundation	9/1/72	1 year	M. Seravalli (4 workshops)	
	Development of teaching/learning guide for maternal health education	Mothers and pregnant women	\$2000/year	HRM	7/1/72	4 months	E. Gridley	
	Involving volunteers in program and service		None	None	Fall 1972	Indefinite	E. Gridley	
PEDIATRICS								
1. Residency Training Program	17 in 1972 28 in 1973		\$195,000/yr.	L.A. County	7/1/72	Continuing	R. Greenberg, MD	
2. Recreation Therapy	2-6; field placements for students		\$70,000/yr.	L.A. County AID	5/1/72	Continuing	B. Johnson	Obstetrician involved
3. Foster Mother Program	Care of high risk children	1400 homes - 3000 children	\$30,000/yr.	State Health Department	8/1/72	1 year	R. Schlegel	
4. Child Care Center Planning	Planning child development center; care for 200 children per day	MLK service area; children of hospitalized employees	\$45,000/yr.	Association for Aid to Crippled Children	10/1/71	1 year	R. Greenberg	
5. Child Care Worker Curriculum Task Force	Develop curriculum to train child care workers		\$15,000/yr.	ETOA	6/1/72	6 months	R. Greenberg R. Frye	

TABLE 3
(cont.)
PROGRAMS/PROJECTS UNDER WAY

Title/Name	Purpose	Target Population (if any)	Approximate Amount of Funding	Source of Funding	Starting Date	Duration	Name of Program Director	Comments
PEDIATRICS (cont.)								
6. Learning Disabilities Program	Interaction with schools for detection, diagnosis and treatment of children with learning disabilities	3 schools, 300 children per year	\$111,282/yr.	Headstart and Model Cities	8/1/72	16 months	R. Greenberg	
7. Biomedical Research			Approx. \$50,000/yr.	NIH	1/1/72	5 years	M. Miller	First biomedical research grant at Drew School
PSYCHIATRY								
1. Mental Health Training Grant	No trainees yet	Mental health trainees	\$103,170/yr.	NIMH	6/1/72	1 year	Dr. Cain	
RADIOLOGY								
1. Residency Training	12 residents			L.A. County	1971	3 years	Dr. Campbell	
2. X-ray Technician	22 trainees			L.A. County	1972	2 years		
3. Nuclear Medicine Tech. Training	4 trainees		\$9600/yr.	Picker	1972	2 years	Dr. Mishkin	
SURGERY								
1. General Surgical Residency Training	7 residents (capacity: 20)			L.A. County	3/27/72	Indefinite	D. J. Alexander	
2. Home Dialysis Training		King-Drew service area	\$87,500	State of California	3/27/72	3 years	Dr. J. E. Hewey	
PATHOLOGY								
None	[Pathology is a participant in P.E.P. (Public Employment Program) and presently employs six persons. phase out in July 1973. It is presently under the aegis of the MLK Hospital, not the Drew School.]							This program is due to

TABLE 4
(cont.)

PROGRAMS/PROJECTS NOT YET FUNDED BUT FOR WHICH FORMAL PROPOSALS HAVE BEEN SUBMITTED

Title/Name	Purpose	Target Population (if any)	Approximate Amount of Funding	Source of Funding	Starting Date	Duration	Name of Program Director	Comments
<u>ANESTHESIOLOGY</u>								
1. Residency Training								
2. Physician Assistant in Anesthesiology								
<u>COMMUNITY MEDICINE</u>								
1. Physician Ass't Training Program	Train 16 PA's; Prepare 15 Pre-PA's for admission to 1973 class	PA students from Greater Watts Model Cities area	\$402,000	Greater Watts Model Cities Agency	10/1/72	1 year		Involves Emergency, Psychiatry, Medicine, Pediatrics, educators, physicians, administrators, counselors, clerical
2. Emergency Medical Services System Development	Improve the system for delivering emergency medical services	L.A. County	\$1,017,253 (\$364,784 for first year)	RMP	1972	3 years		
3. Residency Program in Community Medicine								
<u>MEDICINE</u>								
None								
<u>OBSTETRICS/GYNECOLOGY</u>								
1. Antenatal Diagnostic Services	Provide technical and educational support to pregnant patients		\$37,000/yr.	National Foundation	Jan. 1974	Annually	Erza Davidson, MD	
2. Prenatal Leadership Workshops	Information sharing and leadership development		\$1300	National Foundation		1 year	Erza Davidson, MD	

TABLE 4
(cont.)
PROGRAMS/PROJECTS NOT YET FUNDED BUT FOR WHICH FORMAL PROPOSALS HAVE BEEN SUBMITTED

Title/Name	Purpose	Target Population (if any)	Approximate Amount of Funding	Source of Funding	Starting Date	Duration	Name of Program Director	Comments
PEDIATRICS								
1. Child care center	Care for children of working mothers		\$200,000/yr.	DPSS	11/1/72	Continuing	Robert Greenberg, MD	This grant has, in effect, been funded pending resolution of certain issues.
	Care of children of hospitalized patients		\$200,000/yr.	NIH	1/1/73	3 years	Robert Greenberg, MD	
	Training program for child care workers		\$80,000/yr.	HRD	1/1/73	2 years	Robert Greenberg, MD	Almost assured of funding
2. Genetic Heterogeneity of Hypertension	Determining incidence and familial patterns of hypertension in the adolescent black population		\$181,818 (\$59,760 for first year)	NIH	7/1/73	3 years	Robert Greenberg, MD	
3. Battered Child - Family Reconstitution	To demonstrate a viable alternative to family disintegration in situations where children experience nonaccidental injury, and to minimize the fears and trauma experienced by abused children	MLK service area	\$705,764 (\$283,770 for first year)		5/1/73	3 years	Robert Greenberg, MD	
4. Carbohydrate and Lipid Metabolism During Development			\$159,930 (\$57,231 for first year)		1/1/73	3 years		
5. School Science Lab Program			\$50,000	Model Cities	10/1/72	2 years	M. Miller, MD	Application approved by local Model Cities, given high priority

TABLE 6
(CONT.)

PROGRAMS/PROJECTS NOT YET FUNDED BUT FOR WHICH FORMAL PROPOSALS HAVE BEEN SUBMITTED

Title/Name	Purpose	Target Population (if any)	Approximate Amount of Funding	Source of Funding	Starting Date	Duration	Name of Program Director	Comments
PEDIATRICS (cont.)								
6. Biomedical Research in Educational Consortium	a. Develop biomedical research programs; b. Produce opportunities for 33 minority students per year to learn research methods and seek biomedical careers		\$2,733,344 (\$636,400 for first year)	NIMH	7/1/73	5 years	M. Miller, MD	This is a consortium of 11 biomedical research pro- jects each headed by a principal investigator from one of the Drew depts. (Pediatrics, Surgery, Medi- cine, Obstetrics, Psychi- atry); the proposed purpose is not only to do biomed- ical research but also to train some 33 students at the high school, undergrad- uate and graduate level by involving them in the projects; all 11 projects would be administered by a single program direc- tor, reporting to a coordi- nating committee which would set policy guidelines
PATHOLOGY								
1. School of Medical Technology	To train 8 third-year college students in lab technology		\$75,000/yr.	L.A. County	April 1974	Indefinite	Elias Amador, MD	
2. Sickle Cell Program	Develop instrument to detect sickle cell disease		\$338,000	NIMH	September 3 years 1973			Collaborative effort with J.P.L.
PSYCHIATRY								
1. Maskauri Training Program	Preventive mental health services to families, trains community residents to be counselors	Ujima Village	\$1,040,486 (\$173,277 for first year)	NIMH	July 1973	5 years	R. Jenkins, MD	
2. Drug Abuse				NIMH			Dr. A. Cannon	
3. Key Adult Psychiatry	2 trainees in crisis clinic			L.A. County	May 1972	Indefinite	Dr. J. Mallory	

TABLE 4
(cont.)
PROGRAMS/PROJECTS NOT YET FUNDED BUT FOR WHICH FORMAL PROPOSALS HAVE BEEN SUBMITTED

Title/Name	Purpose	Target Population (if any)	Approximate Amount of Funding	Source of Funding	Starting Date	Duration	Name of Program Director	Comments
PSYCHIATRY (continued)								
4. Master Mental Health Planner	Train mental health planners	Trainees selected from among physicians and allied health workers	\$465,546 (\$111,331 for first year)	WMH	1/1/73	5 years	Dr. A. Cannon	
RADIOLOGY								
1. Continuing Education	12 practicing physicians		\$5000	Picker Foundation	September 1972	9-12 mon.	Dr. Campbell	
2. Armed Forces Registry	2 trainees in a Registry of Radiological Pathology		\$600,00	Private support	1974	Permanent	Dr. Campbell	
3. Faculty Exchange with McBarry	Exchange one professor per year				1973	Annually	Dr. Campbell	
4. Improve Quality of Radiology Services in South Central Los Angeles		Community practitioners, house officers at MLC	\$50,000 (\$25,000/year)	Picker Foundation	1973	2 years	Dr. Campbell	Program proposed to attract prominent radiologists from around the country to King-Drew for short periods of time; send students to take short term courses at other institutions; and bring in high school and college students
5. Continuing Residence Training Program	Family medical program	Residents of service area	0	Department of Community Medicine	1973	Annually		
	Emergency medical program	Residents of service area	0	L.A. County	1973	Annually	Dr. Campbell	

TABLE A
(cont.)
PROGRAMS/PROJECTS NOT YET FUNDED BUT FOR WHICH FORMAL PROPOSALS HAVE BEEN SUBMITTED

Title/Name	Purpose	Target Population (if any)	Approximate Amount of Funding	Source of Funding	Starting Date	Duration	Name of Program Director	Comments
Summary								
1. Transplantation		King-Drew service area	\$40,000	KDP			Indefinite Joseph Alexander, MD	
2. Sickle Cell Disease Center		King-Drew service area						
3. Noninvasive Monitoring/Bioelectric Impedance	Provide routine measurements on patients in ICU	King-Drew service area	\$103,039 (\$64,790 for first year)	NIH	5/1/73	2 years	Joseph Van De Water, MD	
4. Continuous Monitoring of Extra Cellular Potassium	Develop a technique for accurately and continuously monitoring extra cellular potassium		\$24,000	NIH	1973	1 year	Joseph Van De Water, MD	
5. Continuous Monitoring of Myocardial Contractility			\$115,124 (\$69,940 for first year)	NIH	1973	2 years	Joseph Van De Water, MD	
			TOTAL	\$10,000,000 (\$3,600,000 for first year)				

TABLE 5

PROPOSALS PLANNED BUT NOT YET SUBMITTED

(as submitted by department chairmen)

ANESTHESIOLOGY

1. Basic program for nurse anesthetists
2. Inhalation therapy program
3. Residency training program
4. Physician assistant in anesthesia

COMMUNITY MEDICINE

1. Health data center:

Purpose is to develop the skills and resources within the department of Community Medicine required to expand our information gathering and analysis efforts. Target population is the MLK service area. Required funding is unknown, and source will possibly be National Center for Health Services Research and Development. Duration of project: funding sought would support ongoing information system within department. Projected staffing level: health planner, EDP programmer, statistical analyst, survey researcher, social scientist. Skills required: statistical analysis, computer programming, survey research, design of data collected systems, information systems. A health data center would serve the Drew School and other health and welfare organizations (particularly in MLK service area) as a central repository for up-to-date health-related data.

2. Obesity demonstration project:

Purpose is to develop demonstration program aimed at treating and ameliorating obesity and hypertensive health problems in unemployable persons. Target population is obese persons in MLK service area, who were rejected from County employment due solely to obesity. Funding required: \$363,000. Source: HEW. Duration of project: 3 years. Projected staffing level: behavior modification counselor, nutritionist, health educator, nurse, social worker, and clerical (2). Required skills: behavior modification techniques, nutritional counseling, nursing, and health education skills. Program would work closely with MLK Hospital staff, particularly Social Service and Nutrition.

3. Ambulatory health care center:

Purpose is to plan, develop and operate a demonstration ambulatory care center which is relevant to MLK service area. Required funding is not known. Source: HEW. Duration of project: 3 years. Projected

TABLE 5 (continued)

COMMUNITY MEDICINE (cont.)

staffing level: physicians, nurses, dentist, social workers, health care administrator. Skills required: medical nursing, dental, social work pharmacy, administrative. The conceptual model of this proposed facility will contain innovative features in physical plant, management, service delivery, staffing, etc.

4. Residency program in family practice:

Purpose is to develop and implement a residency program in family practice for resident physicians.

MEDICINE

1. Hypertensive disease in black population:

Phase I includes incidence and identification in a portion (25,000) of our service area--mobile unit may be best approach. Phase II, education program--size of target population to be determined. Phase III includes screening for curable disease--methodology of acceptability and cost efficiency important part of this program. Phase IV includes network approach to long-term care of chronic hypertension--eventual population is entire service area. Most phases will require support of Psychiatry, Pathology (Lab Medicine) and Community Medicine. Phases III and IV, particularly, require organization of health facilities in community. NIH support will be sought for all phases. First 12 months, \$75,000. Two four-member teams.

2. Chronic alcoholism and its complications:

Joint program with Psychiatry and self-help groups in community. Mental Health Fund. Psychiatrist, psychiatric social worker, medical team approach. Start with clinics located in community. \$60,000/yr. Number optional.

3. Diabetic management:

Intrahospital and clinic program for first 12 months. No additional support until extended to community. ADA funds to be sought at that time. Medical educators are in-house.

4. SS disease program:

As part of the total King-Drew complex.

TABLE 5 (continued)

OBSTETRICS/GYNECOLOGY

1. Maternal and child care proposal:

Joint MLK/JPL grant for maternal/child care services. Purpose is to work with this engineering group to analyze, improve and provide newer approaches to delivering maternal and child care services basically from the viewpoint of how the providers should develop programs and interrelate in the MLK service area (for example, Health Department, Watts Multipurpose Health Center, private physicians and groups, MLK, etc.). Probable level of total funding: \$500,000-\$750,000/yr. Source: NASA and probably HEW. Probable duration: 5 years. Other departments: principally Pediatrics, with wide support from other hospital services and systems to include Psychiatry, Nursing, Social Service, Medical and Hospital Administration.

2. Cancer screening and therapy program:

Purpose is to provide comprehensive identification, treatment and follow-up of GYN cancer patients. Target population is MLK service area. Probable level of funding required: \$100,000. Source of funds: American Cancer Society, federal. Probable duration: indefinite. Skills needed: professional, social service, clerical. Other departments: Community Medicine.

3. Maternal health services for adolescents:

Target population is teenage girls/school-age girls. Probable level of funding required: \$300,000. Likely sources: federal. Probable duration: 3-5 years. Projected staff level: 20-25 people. Kinds of skills needed: MD's, nurses, social service, dietary, clerical, technical, laboratory. Other departments: Community Medicine, Psychiatry, Pediatrics.

PATHOLOGY

1. Develop an instrument to do automated urine analysis. Prospective funding source: NIH Expected funding level: \$700,000 over three years. Expected starting date: 1974. Collaborative effort with Jet Propulsion Laboratory as a subcontractor.

PEDIATRICS

1. Program for care of battered children, infants with failure to thrive within total program of child care center:
Purpose is rehabilitation of children and families with this problem. Funding: approximately \$100,000 per year, by NIMH. Planning will be with department of Psychiatry. Duration: 3 years, initial grant.

TABLE 5 (continued)

PEDIATRICS (cont.)

2. Biomedical research projects, developed individually by faculty members.
3. Genetics center:

This program will be primarily based at Harbor General Hospital, with Dr. Rimoin as principal investigator. A number of component research projects will be submitted, to share in a coordinated genetics program. Funding source: NIH. Duration: 5 years. Level of funding difficult to predict. OB to be a part of program.

4. Sickle cell proposal:
As part of an institutional application.

5. Maternal and infant care project:

This program, developed primarily by E. Davidson, is in varying stages of funding and development.

PSYCHIATRY

None

RADIOLOGY

1. Sabbatical physicians:

Program to send physicians to other medical schools. Level of funding: \$5,000. Funding source: Picker. Duration: 1 year. Staff: Two MD's.

SURGERY

1. Trauma Center

The level of funding hopefully will be \$250,000 from HEW (NIH). Probable duration: 3 years or indefinite. Will require multiple disciplinary medical and paramedical skills, using people from Anesthesiology, Medicine, Pediatrics, Radiology, and probably the Emergency Service.

3.4 FINANCIAL IMPLICATION OF PROGRAM DEVELOPMENT

Funded Programs

The number and dollar value of program grants and contracts have increased dramatically since the first RMP grant in 1969. Table 6 shows this growth on a year-by-year basis.

Proposals Outstanding

The dollar value of outstanding proposals is also impressive, totaling approximately \$10 million. (See Table 4.) If an average overhead rate of 26% of direct costs is applied, the total funds requested approximate \$12.6 million. Most projects would run for more than one year, and the estimated total of the first year funding requested is approximately \$4.5 million, including \$3.6 million in direct costs and an estimated \$900,000 in indirect costs.

Programs Being Planned

Programs still in the planning or proposal preparation stage are more difficult to estimate, but information supplied by the departments indicates that there may be as much as another \$2-3.5 million worth of proposals in the works. (See Table 5.)

Master Plan Program Development

The program areas sketched out by the program developing steering committee and its associated task groups are not at the point where funding estimates can be made. Yet, if a recommendation-by-recommendation analysis is made, some order-of-magnitude estimates are possible. (See Table 7.) This analysis indicates that an additional \$1.5-3.9 million of proposals could be generated as a result of the Master Plan Study work.

This estimated level of funding, if received from outside sources might carry with it from \$300,000 to \$800,000 in indirect cost recovery.

Staffing

At present, Drew has a full-time faculty numbering some 70 persons. Its annual volume of grants and contracts (including indirect costs) is running at a \$3.5 million level. If a success rate of 50% is assumed on outstanding proposals and if present contracts and grants continue at about their present levels (some programs will phase out, others will continue, and some, such as the County contract, should increase with an increase in faculty size), within about two years Drew will be operating at an annual level of \$5.8 million in grants and contracts, requiring a professional staff of some 115 persons.

If we add to that the programs currently being planned at an assumed success rate of 25% and the total reaches \$6.3-6.5 million in about three years, a professional staff of 125-130 will be required.

Finally, if we add the programs envisioned by the Master Plan process at a success rate of 25%, the total reaches \$6.7-7.5 million in about five years, requiring a professional staff of some 135-140 persons.

Table 8 summarizes the dollar value and staffing requirements of present and prospective programs. Using these data, and assuming some phase out of present programs over the next five years, we estimate that Drew will require the total levels of professional staff shown in Table 9.

TABLE 6

SUMMARY OF GRANTS, CONTRACTS AND GIFTS

AWARDED THROUGH JANUARY 15, 1973*

<u>Program/Project</u>	<u>Funding Source</u>	<u>Duration</u>	<u>Direct Costs</u>	<u>Indirect Costs</u>	<u>Total</u>
		1969			
WWRMP - Core	RMP	7/1/69 - 12/31/69	\$70,798		\$70,798
Community Medicine and Faculty	RMP	7/1/69 - 12/31/69	\$134,727		\$134,727
Community Medicine	Markle Foundation	1/1/69	\$37,000		\$37,000
			\$242,516		\$242,516
		1970			
WWRMP - Core	RMP	1/1/70 - 8/31/70	\$107,601	\$35,035	\$142,636
Community Medicine and Faculty	RMP	1/1/70 - 8/31/70	\$357,174	\$67,662	\$424,836
MEDEX (Demonstration)	HSMHA	6/30/70 - 12/31/71	\$355,742	\$77,403	\$433,145
Area IX - Core	RMP	9/1/70 - 8/31/71	\$95,525	\$33,032	\$128,557
Community Medicine and Faculty	RMP	9/1/70 - 8/31/71	\$407,524	\$149,799	\$557,323
			\$1,323,566	\$362,931	\$1,686,497
		1971			
Health Center Eval.	OEO	7/1/71 - 6/30/73	\$219,179	\$58,653	\$277,832
Area IX - Program Staff	RMP	9/1/71 - 12/31/72	\$215,683	\$61,307	\$276,990
Community Medicine and Faculty	RMP	9/1/71 - 12/31/72	\$376,221	\$114,570	\$490,791
Master Planning	BHME	5/10/71 - 4/28/72	\$100,000		\$100,000
Planning - Allied Health Science	PIHE	5/10/71 - 8/31/73	\$150,000		\$150,000
Family Planning Services	LARFPC	9/1/71 - 9/30/71	\$2,102	\$394	\$2,496
Family Planning Services	LARFPC	10/1/71 - 3/31/72	\$18,404	\$4,000	\$22,404
Faculty Services	L.A. County	7/1/71 - 6/30/72	\$720,780		\$720,780
Conference of Black Nurses	Weir Foundation	7/71	\$5,516		\$5,516

TABLE 6 (continued)

<u>Program/Project</u>	<u>Funding Source</u>	<u>Duration</u>	<u>Direct Costs</u>	<u>Indirect Costs</u>	<u>Total</u>
Master Planning	Commonwealth Fund	6/1/71 - 73	\$100,000		\$100,000
Symposium Nutrition	Mead Johnson	6/11/71	<u>\$400</u> \$1,908,285	\$238,924	<u>\$400</u> \$2,147,209
		1972			
Medex (Demonstration)	HSMHA	1/1/72 - 12/31/72	\$316,083	\$72,685	\$388,768
Neonatal Infections	NIAID	2/1/72 - 1/31/73	\$50,000	\$9,360	\$59,360
EMS Planning Conference	RMP	6/72	\$5,000		\$5,000
EMS Planning Conference	HEW	6/72	\$2,500		\$2,500
Functional Task Analysis	BHME	6/19/72 - 6/18/74	\$499,704	\$123,669	\$623,373
Residency Training Model	NIMH	7/1/72 - 6/30/73	\$103,170	\$8,254	\$111,424
Volunteer Stroke Program	RMP	9/1/72 - 12/31/72	\$10,397	\$1,646	\$12,043
Family Planning Services	LARFPC	4/1/72 - 9/30/72	\$47,223	\$6,410	\$53,633
Master Planning	BHME	5/ /72 - 3/31/73	\$150,000		\$150,000
Curriculum Planning - Child Center	EYOA	4/1/72 - 12/31/72	\$15,000		\$15,000
Public Services Careers	CWE-CA	8/1/72 - 7/31/73	\$10,000		\$10,000
Physician Assistant Training	BHME	6/30/72 - 6/29/73	\$196,444	\$15,712	\$212,156
Early Detection - Learning Disability	CDA	10/1/72 - 9/30/73	\$111,282		\$111,282
Sickle Cell	CDA	10/1/72 - 9/30/73	\$237,177		\$237,177
Family Planning Services	LARFPC	10/1/72 - 9/30/73	\$153,779	\$6,000	\$159,779
Foster Care Program	DPH	7/1/72 - 6/30/73	\$30,000		\$30,000
Faculty Services	L.A. County	7/1/72 - 6/30/73	\$1,450,000		\$1,450,000
Planning - Child Care Center	AACC	10/1/72 - 3/31/73	\$45,410		\$45,410
Neonatal Consultation	Ross Labs		\$5,000		\$5,000
Planning - Child Center	AACC	10/1/72 - 3/31/72	\$6,775		\$6,775
Faculty Fellowship	Macy Foundation	7/1/72 - 6/30/73	\$18,000		\$18,000

TABLE 6 (continued)

<u>Program/Project</u>	<u>Funding Source</u>	<u>Duration</u>	<u>Direct Costs</u>	<u>Indirect Costs</u>	<u>Total</u>
Board of Directors	Mars Foundation		\$ 2,500	0	\$ 2,500
Board of Visitors	Kaiser Foundation		\$ 15,000	0	\$ 15,000
Continuing Medical Education	California Medical Association		\$ 2,500	0	\$ 2,500
			\$3,482,944	\$ 243,736	\$3,726,680
		1973			
Area IX - Program Staff	RMP	1/1/73 - 6/30/73	\$ 91,549	\$ 30,221	\$ 121,770
Volunteer Stroke Program	RMP	1/1/73- 6/30/73	\$ 48,572	\$ 11,251	\$ 59,823
Community Medicine	RMP	1/1/73 - 6/30/73	\$ 127,930	\$ 43,654	\$ 171,584
Alcoholism Survey	DMH	1/1/73 - 6/30/73	\$ 13,800	\$ 1,200	\$ 15,000
"Dean's Funds"-Unrestricted	Santa Anita Foundation		\$ 5,000	0	\$ 5,000

* Amounts and titles may not exactly match data in Table 2 due to differences in categorization and funding periods.

TABLE 7

DURATION, ESTIMATED COSTS, AND PROSPECTIVE FUNDING SOURCES FOR MASTER PLAN PROGRAMS

<u>Program Area</u>	<u>Possible Duration</u>	<u>Estimated Annual Direct Cost-Drew</u>	<u>Prospective Funding Sources</u>
1. Design and implementation of an improved health care delivery system for the MLK-Drew service area	5 years	\$20,000-35,000/yr.	Foundations Health Services R&D (HSMHA) L.A. County
2. Coordinative mechanism for post graduate training programs in the health professions	indefinite	\$5,000-15,000	MLK-Drew
3. Community health worker training in hypertension management	indefinite	\$80,000-100,000	H.S.M.H.A.
4. Training nurse practitioners for the hypertension clinic	indefinite	\$50,000-75,000	H.S.M.H.A.
5. Consumer education program in hypertension	continuing	\$100,000-200,000	UCLA USC American Heart Assoc.
6. Hypertension information system for community health practitioners	continuing	\$100,000-200,000/yr. (computer and communications cost, mainly)	NIH American Heart Assoc.
7. Child care center	continuing	already proposed - in planning stage	L.A. County
8. Programs of family life education	continuing	\$100,000-200,000/yr.	Foundations, nonprofit agencies
9. School health and learning disabilities	continuing	\$200,000-300,000/yr.	NIMH Office of Education
10. Work with gangs	continuing	\$30,000-50,000	State Dept. of Education County Health Dept.
11. Maternal and child health R&D	continuing	\$100,000-200,000	NIH

TABLE 7 (continued)

<u>Program Area</u>	<u>Possible Duration</u>	<u>Estimated Annual Direct Cost-Drew</u>	<u>Prospective Funding Sources</u>
12. Fetal I.C. at MLK		\$100,000-150,000	L.A. County
13. Program planning and review mechanism	continuing	\$20,000-25,000/yr.	Drew and MLK
14. Drug and alcohol abuse education programs aimed at:	indefinite	\$100,000-800,000	L.A. County
- users			NIMH
- potential users			NIH
- patent			LEAA
- educators			SAODAP
- law enforcement officials			NIAAA
- physicians			
- druggist			
- political leaders			
15. Alternatives to drug use	continuing	\$200,000-1,000,000	L.A. County
			NIMH
			NIAAA
			LEAA
			SAODAP
16. Condusive mechanism for drug treatment programs	continuing	\$25,000-50,000	(same)
17. Detoxification program	continuing	\$150,000-300,000	L.A. County
18. Research on drug abuse prevention and treatment techniques		\$100,000-200,000	NIMH
			LEAA
		<u>\$1,480,000-3,900,000</u>	

TABLE 8

SUMMARY OF PRESENT, PLANNED, AND PROSPECTIVE PROGRAM ACTIVITY

<u>Program</u>	<u>Estimated Annual Dollar Value - Direct Cost</u>	<u>Assumed Percent of Success</u>	<u>Expected Dollar Value</u>	<u>Estimated Number of Faculty and Professional Staff (F.T.E.'s) Required to Meet Program Requirements*</u>
Programs currently under way	\$3,500,000	100%	\$3,500,000	70
Proposals submitted but not yet funded	\$4,600,000	50%	\$2,300,000	46
Programs planned but not yet in proposal stage	\$2,000,000-3,000,000	25%	\$500,000-750,000	10-15
Master planning programs	\$1,500,000-4,000,000	25%	\$370,000-1,000,000	7-20

*Present funding levels average out to about \$50,000 per faculty man-year, which is in line with rules of thumb used in government contracting for professional services. The \$50,000 per man-year figure includes both direct and indirect (supporting services) costs.

TABLE 9

DREW'S ESTIMATED PROFESSIONAL STAFF REQUIREMENTS

1973-1978

<u>Year</u>	<u>Expected Professional Staff Level</u>
1973	70
1975	120
1976	130
1978	150

(See Section 5.6 for a more detailed projection of personnel buildup.)

4: Organization

4. ORGANIZATION

Part of the responsibility of the consultant team for the Master Plan Study was to analyze the administrative organization of the Drew School. The objective was to find alternative ways of strengthening that organization internally and providing for more effective relationships with King Hospital, Los Angeles County, and the community. This analysis has resulted in recommendations both for a long term organization and for steps which can be taken in the immediate future. We shall address ourselves first to the organization, in the long term, of a joint administrative structure for a genuinely unified King-Drew Medical Center, and then to more immediate considerations.

4.1 THE KING-DREW MEDICAL CENTER

Satisfaction of community health service requirements (as both the community and its requirements are defined) is a joint responsibility of King and Drew. Recognition of limited financial resources available or foreseeable makes all the more imperative the objective of creating, over time, a single Medical Center composed of the school, the hospital, and the network of satellite facilities.

Positive steps have been taken to unify Drew and King. Retreats have been held for both staffs to identify, discuss, and resolve mutual problems. A King-Drew Medical Center Committee has been established. These are beginnings. We are well aware of the apparently insuperable obstacles, principally the lack of money and the nature of County restrictions, in the way of long term development of a single center. But we believe that an ad hoc center already exists, and we recommend that formal establishment of a King-Drew Medical Center be adopted as the long range goal of governance and administration.

Developing new and better methods of delivering health care calls for developing new methods of administration and control. We recommend that another long range goal be the creation of a joint King-Drew board of regents to govern the medical center. We recognize that such a joint board, controlling policy and finance, is not possible in the present administrative and legal framework. In fact, the conditions under which it could be done now would be detrimental to both the Drew School and its community. If it were attempted under current constraints, it would be necessary, in effect, to move the Drew School into an even closer control relationship with the County. The cost to Drew now would be loss of autonomy and its own board, including the community representation on that board. This is not acceptable. Recognizing that, over time, things do change, and that new solutions require new organizational patterns and relationships, we urge the Drew School and King Hospital to work together to create, in the long term future, a climate of decentralized or

delegated County authority which would enable a true medical center organization to exist. We urge both institutions to explore during the coming years the means of making the board of regents possible.

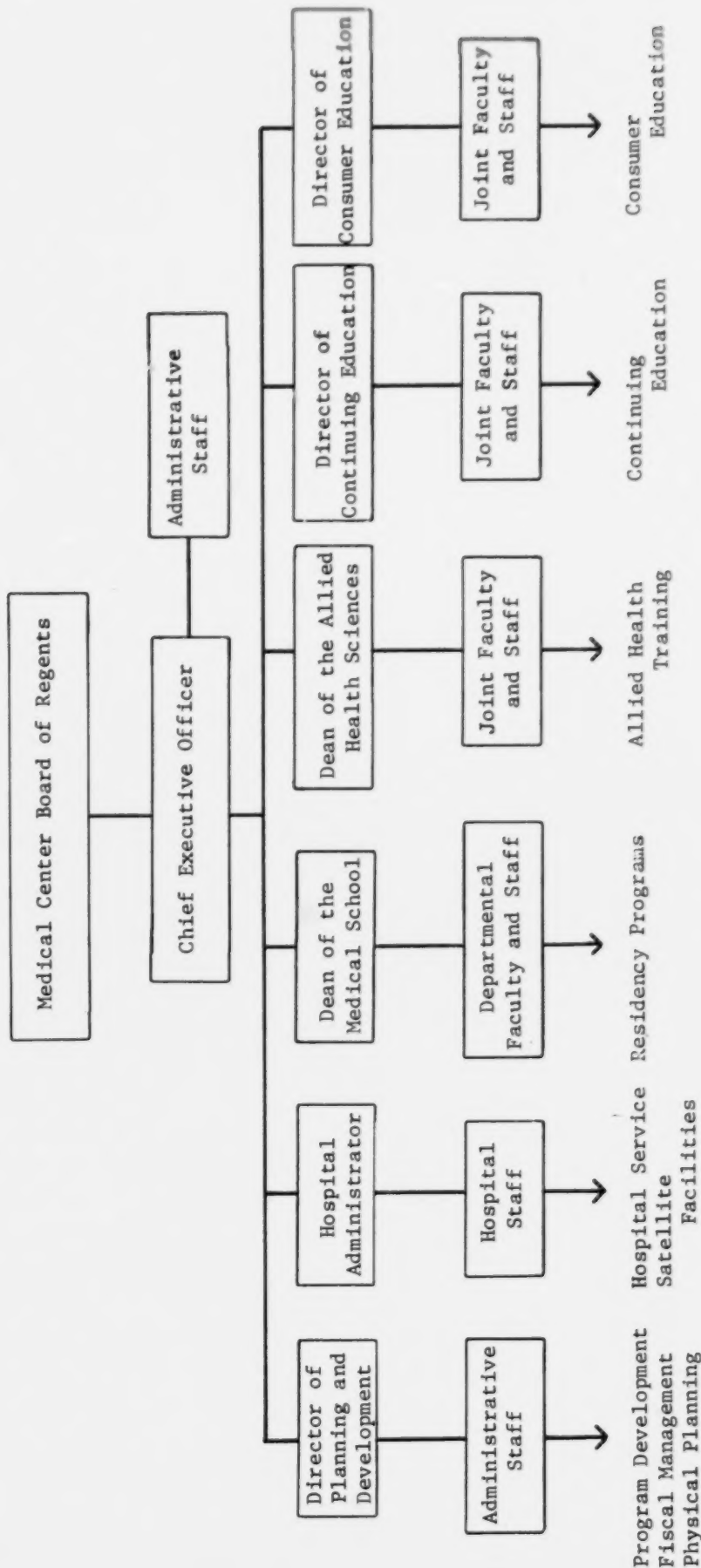
We recommend that, in time, a chief executive officer of the Medical Center be appointed to report to this board. This officer would have executive authority for the governance and administration of the Medical Center. Financial support of this office should be provided by both the hospital and the school.

We recommend that for both the long and short terms an office of planning and development be established for coordinated planning by both institutions, fiscally supported by both and whose first charge is to advance the concept of a true center in the areas of program development, financial management, and physical development. This office is not a panacea for all these problems. To assist it, we suggest creation of a Medical Center committee whose task is to review (at least annually) and evaluate all center programs and recommend programs for development. This committee should be composed of the director of planning and development, the hospital administrator, the dean of the Medical School, the dean of Allied Health Professions, the directors of Continuing Education and Consumer Education, assisted by others as required.

We recommend that the director of clinical services or the hospital administrator be responsible for all hospital programs and report to the chief executive officer of the Center; that the dean of the Medical School be the director of the departments and report to this executive and have responsibility for administration of all residency programs; that the dean of Allied Health Professions also report to this executive and have responsibility for joint King-Drew programs; that the directors of continuing education and consumer education also report to the chief executive of the Center and have principal authority for direction of these joint programs.

The organization we propose as a long term goal directly relates administrative structure to the major program categories of the Center and is illustrated on the following chart. Organization takes time and should not be permitted to preclude more immediate steps toward early integration at working levels. Both the office of planning and development and programs of allied health professions are immediate opportunities to begin creation of a true center concept.

Figure 1
THE KING-DREW MEDICAL CENTER,
PROPOSED ORGANIZATION, LONG TERM



Medical Center Committee

Director, Planning and Development
Hospital Administrator
Dean, Medical School
Dean, Allied Health Sciences
Director, Continuing Education
Director, Consumer Education
Director, Ambulatory Care Center
Director, Learning Resources Center

Note: This organization chart has been developed as a preliminary and tentative response to problems which will change in unforeseeable ways during the coming years. It is presented as one alternative and as a basis for discussion rather than as an ultimate solution.

4.2 ORGANIZATION FOR PROGRAM PLANNING

The Drew faculty is presently organized along departmental lines corresponding largely to the various clinical specialties of medicine, surgery, pediatrics, obstetrics, psychiatry, pathology, radiology, anesthesiology. A most important department is community medicine, which has taken on a variety of tasks including developing data on the community, mounting the physician assistant training programs, and the conduct of various grants and contracts. The department of Community Medicine has been one of the key forces behind the development of two organized areas of activity which cut across the clinical specialties: family practice and emergency services. These last two areas will become departments in their own right, illustrating another function of the department of Community Medicine--to create new areas or forms of health care delivery.

Departments are the basic organization units in Drew. They are the units to which all faculty and staff are attached who are not part of the immediate Office of the Dean. Most programs originate and are lodged in the various departments and faculty gain much of their professional identity from their departmental associations. In organizing along departmental lines, Drew has followed the pattern of most academic medical institutions in this country.

In our talks with faculty members and administration, we found little desire or evidence for a radically different kind of faculty organization, one which, for example, would aggregate departments, producing another layer between existing departmental chairmen and the Drew administration, or one which would split up existing departments and place faculty and staff in a new configuration.

Moreover, it does not seem to us that a radically different faculty organization is required for Drew to carry out its basic mission of raising the level of health in the community. The disciplines which underlie the departmental organization probably will remain the most durable category for sub-dividing and/or aggregating medical manpower. Problems will change, modes of delivery will change, sub-specialties and new specialties will emerge and all will need to be accommodated, but there are other ways of handling these new challenges than re-working the basic faculty structure.

There are needs for some additions to the administrative organization to ease faculty collaboration and to infuse departmental programs with school-wide perspective.

The need for ways to foster collaboration and an institutional perspective comes from several sources, many of which have been alluded to previously in this report:

1. That the health care problems in the service area frequently present themselves in such a way that interdisciplinary collaboration is required to deal effectively with them.
2. That the hospital will become only one of many settings for the delivery of health care and the teaching of professionals by faculty members.
3. That new sources of funding may not, like NIH, be geared to the traditional clinical disciplinary specialties.
4. That increasingly deeper understanding of the community will be required if Drew is to fulfill adequately its central mission.
5. That general practitioners in the community need to relate more easily to Drew.
6. That there are certain areas of program development which have a high priority for the institution as a whole, but which may not have high priority when viewed from a particular department's point of view.
7. That Drew needs to pay attention to increasing the amount and quality of internal cohesiveness if it is to discharge adequately its institutional responsibilities.
8. That ways need to be found of constructively dealing with the inevitable conflict in the faculty around the management of patients, leadership and program development, and staking out departmental territory as each department seeks to grow and expand.
9. That ways need to be found to enable individual faculty members to pursue activities or areas of professional development which may not be possible or attainable within their own departmental structures.

To meet these needs, four major lines of activity are recommended:

1. Establish an office of director of planning and development in the Office of the Dean, staffed by several different kinds of people including grant writers, a community relations person, a fund raiser, and a public relations specialist.
2. Establish a program planning and review group which will annually compile a review of all the program activities of the Drew School and recommend to the dean and the board new areas which should be developed, along with recommendations for implementation.

3. Institute a policy that allows the development of interdisciplinary programs and the shifting of faculty temporarily from department to department as needed.
4. Give the department of Community Medicine an explicit (though not exclusive) charter to "grow" new activities which may ultimately become self-sufficient and which would not logically develop in any of the existing clinical departments--the prototype for this exists in connection with the development of Emergency Medicine and Family Practice.

The following sections explore each of these recommendations in more detail.

4.2.1 Establish an Office of Director of Planning and Development

We recommend that Drew proceed to establish and staff a permanent position of director of planning and development in the Office of the Dean. His (or her) initial function should be to provide continued impetus to the present program development activity, working to further the process by which a workable health care system can be designed and implemented for the service area, and facilitating school-wide and community collaboration in developing programs in the areas chosen by the Master Plan Steering Committee, based on the results of the faculty and staff survey.

Over the longer term, his primary function would be to continue to stimulate broadly based education and service programs in Drew which are innovative and multidisciplined in nature, attracting the support of a diversified set of funding sources. He should also work closely with architects to translate Drew's plans into physical facilities. He should be the chief planning officer, working closely with the dean, the hospital administration, the director of administration and finance, the department heads, and community leaders in shaping Drew as an institution through its program activities.

It will be important for the director of planning and development to have the full support of the dean in order that he may constructively shape the program activities of the school.

The director of planning and development must be skilled in the art of making things happen, experienced in program planning, and able to call on the knowledge of people familiar with the various sources of federal and state support for programs. Moreover, he must be credible to the faculty and to community leaders.

The office of the director of planning and development will probably need to be staffed initially by one person and a secretary. Over a period of two to three years, however, as funds become available other persons will need to be added.

The funds to pay the director of planning and development initially will probably have to come from institutional sources unless outside support can be obtained from foundation sources.

Within about two years, the office of the director of planning and development should be self-supporting through the overhead dollars received on new grants and contracts generated as a result of his efforts. But his real justification will be based on his ability to knit the programs and plans of the school and the hospital more closely together, to help the dean and faculty, together with the community, shape priorities and stimulate activities which have a tangible impact on the service area.

We believe that the establishment and staffing of this position to be critical to the development of Drew over the next decade. The job cannot be done by existing departmental people alone because they cannot speak for the school as a whole. It should not be done by the dean because of other demands on his time and because it is a job that should be built around specialized skills.

This recommendation, along with a detailed position description and proposal qualifications have been transmitted to the administration of the Drew School. The board of directors has approved the position, in principle.

4.2.2 Establish a Program Planning and Review Group

We recommend that a successor group to the Steering Committee be established, consisting also of faculty, board, hospital, administrative, and several more community representatives. The committee membership should be on a rotating basis so that about one-third of the membership would be changed each year to provide new perspectives, share the workload, and yet provide continuity. As with the present steering committee, one or two faculty members at large and one member of the Faculty Executive Committee should be elected by the Faculty Council. The dean should appoint a second representative from the Faculty Executive Committee. The board chairman should appoint two or three board representatives. The King Hospital administrators and the dean of the medical school should be represented. Two or three community representatives should be invited to join by the dean and/or chairman of the board after consulting with community leaders and community residents. Community representatives and board members should be paid travel, baby-sitting, and other expenses in connection with their work on this committee.

The director of planning and development should be the executive secretary of the committee and should be able to convene the group.

We see the program planning and review group as having several specific functions:

1. To review all major proposals (of about \$100,000 per year and

over) and advise the proposer on shaping the proposal to build-in other disciplines, and to make it consistent with the basic institutional goals and strategies of Drew. The criteria for selecting which proposals should receive active review by this group should include the following:

- a. Projects which represent an expression of Drew's commitment to the community.
 - b. Projects which are large and interdisciplinary in nature.
 - c. Projects which will have visibility in the community.
 - d. Projects which will require the active support of the Drew administration.
2. To be the group to which the director of planning and development looks for guidance in developing new program areas--a group to whom he can submit proposals and ideas to have them extended, shaped, and clarified.
 3. To prepare, with the help of the director of planning and development, an annual review and evaluation of ongoing programs and recommendations for new programs for the coming year--a series of recommendations which would be submitted to the dean and board of directors for their approval and sanction.
 4. To sanction task groups to look into new high priority areas and develop recommendations for action.
 5. To press for community involvement in program planning and development.

We recommend this group be constituted by the summer of 1973, and that it make its first report to the dean and the board of directors in January 1974.

4.2.3. Recommended Administrative Changes

Certain administrative procedures will need to be instituted or existing ones modified to enable program development and implementation to proceed smoothly. Most of the following recommendations deal with how the time and expenses related to program development are charged.

1. Develop a series of Drew project accounts for collecting the time and expenses of faculty members devoted to developing programs which are not lodged, during the planning stage, in a particular department. These accounts can enable Drew administration, faculty,

and board to know how much time and effort is spent in developing a particular proposal. It also provides a mechanism for Drew funds (as opposed to departmental funds) to be expended in paying for supporting services, printing, consulting services, and miscellaneous community participation expenses. Departments would be reimbursed for the expenses of full-time faculty members charged to these accounts.

2. Make possible interdepartmental shifts of personnel by enabling the person involved to remain administratively attached to his regular department but to have part of his time paid by a budget of another department and credited to his original department. Thus, if a member of the department of Pediatrics wanted and was needed to spend half of his time for six months in the department of Community Medicine developing the Family Practice Residency Program, his department would not have to bear the whole burden.
3. For large endeavors, particularly those which will require separate physical facilities, keep open the possibility of forming a separate administrative unit reporting directly to the dean. Put another way, consider developing "institutes" to house permanent activities of a multidisciplinary nature.
4. Create, through a specific fund raising effort, a special "Dean's Fund," a discretionary fund which can be used as seed money to assist in the development of programs of special interest to the Drew School.

This money can be used in several ways:

- a. Supplementing existing program funds to enable a special facet of a program to be expanded.
- b. Initial development of special programs.
- c. Inducement money to reward interdepartmental collaboration beyond that which would be minimally needed to implement a particular program.
- d. Support for especially promising younger faculty members who do not yet have the reputation or know-how to derive funding for their initial work.

4.2.4. Give the Department of Community Medicine an Explicit (Though Not Exclusive) Charter to "Grow" New Activities.

Each department will develop activities which are more or less self-sufficient. Surgery is developing sub-specialties, as is Medicine.

Pediatrics is engaged in the development of a child care center.

There will be some activities such as the Family Practice Residency Program or the Emergency Services Program which cut across several departments. These cross-departmental activities need a place to be developed to the point where they can find a permanent home or can become free standing in their own right. The department of Community Medicine has, and is, serving this function in part, and represents an administrative entity which can serve as a seedbed. It is also the only department capable of taking a broad community viewpoint, because it is not wedded to any one particular discipline.

Some or part of the newer programs in consumer education, drug abuse, etc., may most logically be developed in or under the supervision of the department of Community Medicine before being assigned to other departments or being related directly to the Office of the Dean.

4.3 ADMINISTRATIVE ORGANIZATION

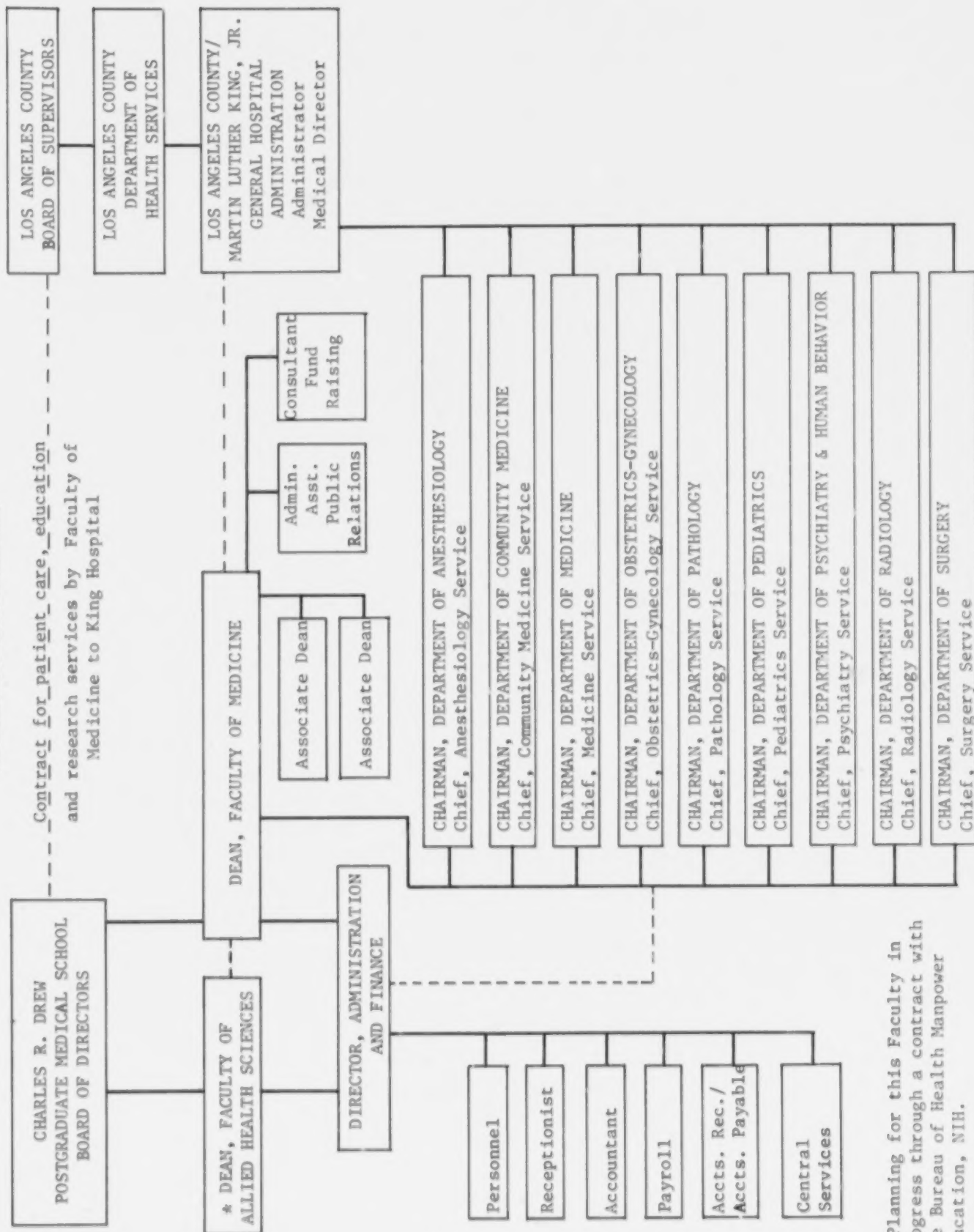
The administrative organization of the Drew School should be geared to perform the following functions:

1. Provide effective day-to-day support services and administrative coordination to all units of the school.
2. Provide a school-wide perspective for program planning, administration, and provision of support services.
3. Foster and maintain close, constructive relationships with community groups, institutions, and agencies.
4. Develop strong and continuing financial support from diversified sources, including the generation of unrestricted funds which can be allocated by the dean for high priority needs.
5. Establish a closely knit dean's office that can function as a management team.
6. Stimulate collaborative efforts among the faculty in planning and carrying out programs in new areas.
7. Provide for review of major proposed activities.
8. Provide mechanisms for maximum exchange of information.
9. Develop and maintain effective public information/public relations programs with all of Drew's constituencies.

10. Facilitate the exchange and utilization of faculty and staff among the departments in planning and conducting services and educational programs.

The present Drew administrative structure is illustrated in the following figure.

PRESENT DREW ORGANIZATION



* Planning for this Faculty in progress through a contract with the Bureau of Health Manpower Education, NIH.

4.3.1 Proposed Short Term Administrative Organization

The proposed administrative organization adds two major elements to the present structure: (1) a director of planning and development and a supporting staff including a fund raiser and an assistant to the director of planning and development for community relations; and (2) a director of the proposed learning resources center.

The present public relations function would, under the proposed organization, be shifted to the office of the director of planning and development.

The dean of the medical school would, in the proposed organization, have three key administrative people reporting to him, together with the two present associate deans.

The job of the director of planning and development has been described in the previous section (4.2.1). Supporting staff positions and the job of director of the learning resources center are described in the following paragraphs.

a. Assistant for Community Development

The assistant for community development should be directly responsible to the director of planning and development. He should work with the director in initiating and coordinating Drew's relationships with organizations, agencies, and institutions in the community, including community groups, police and fire departments, social service agencies, schools, etc.

Working closely with (and perhaps funded in part by) the department of Community Medicine and with other parts of the Drew School, he should be aware of the existence of community organizations and agencies, their activities and key people. He should push for concrete working relationships between various parts of Drew and those community organizations to improve health care capability in the community. He should meet frequently with representatives of community organizations and agencies and should develop affiliations, agreements, and other expressions of relationships wherever possible. He does not, in any way, obviate the need for an ombudsman, a person who serves a wholly different function.

The assistant for community development should be a primary resource to the director of planning and development in identifying and involving community people in the program planning activities of Drew. He should become familiar with the possibilities and limitations of the 1,000-family sample being developed by the department of Community Medicine and should assist community medicine in the utilization of that sample and in

developing benefits to persons in that sample.

b. Public Information Officer

The information officer should be directly responsible to the director of planning and development and should handle media relations, publications, editorial services, and graphic services. The person filling this job should be experienced in public media relations and the dissemination of information by all available means. He or she should maintain close contact with local newspapers. The information officer should provide editorial and related support services to department chairmen in the preparation of their brochures, proposals, and other written and graphic material. He or she should work closely with the dean and his assistants in the development of press releases and related material designed for public consumption.

c. Fund Raiser

The fund raiser should make and sustain contact with wealthy prospective contributors and executives of foundations for the purpose of acquainting them with Drew's plans and needs and soliciting from them contributions both for operating funds and the building of an endowment. Annually, the fund raising officer should prepare and execute a fund drive, drawing upon his contacts and those of the dean, board members, members of the board of visitors, and faculty. The fund raising officer should be in close personal contact with the dean to insure that his own articulation of Drew's plans and needs are accurate and reflect the latest thinking of the administration and the board.

d. Director of the Learning Resources Center

The decision has been made to proceed with the planning of the Learning Resources Center as the first component of the school's development program. This decision generates yet one more decision--that the director of Learning Resources Center must be recruited as soon as possible to lead the planning effort.

In order for the LRC to function effectively, the director should occupy a place in the organization structure parallel to the director of administration and finance and the director of planning and development. He should report directly to the dean of the medical school. Lacking this authority, he will not be able to mobilize needed services, and the proliferation of ill-used services, costly to equip and sustain, is likely to be the result.

Candidates for the position of director should have experience

in other institutions which qualify them as well-rounded biomedical communications specialists. Although the director may have had his professional training in a variety of fields (librarianship, communications media, educational program development) he (or she) should demonstrate a breadth of understanding rather than narrow expertise in any one field.

Qualifications include:

Administrative talent and experience.

An understanding and appreciation of medical educational development, research, and evaluation.

Experience and success in obtaining grants.

Familiarity with communications media.

Sensitivity to community cultural aspirations.

An orientation toward service and the ability to get along with people.

It should be noted that the average salary of a director of biomedical communications is about \$22,500. Top salaries run to \$30,000 and more.

The proposed short term administrative organization structure is shown in the following figure.

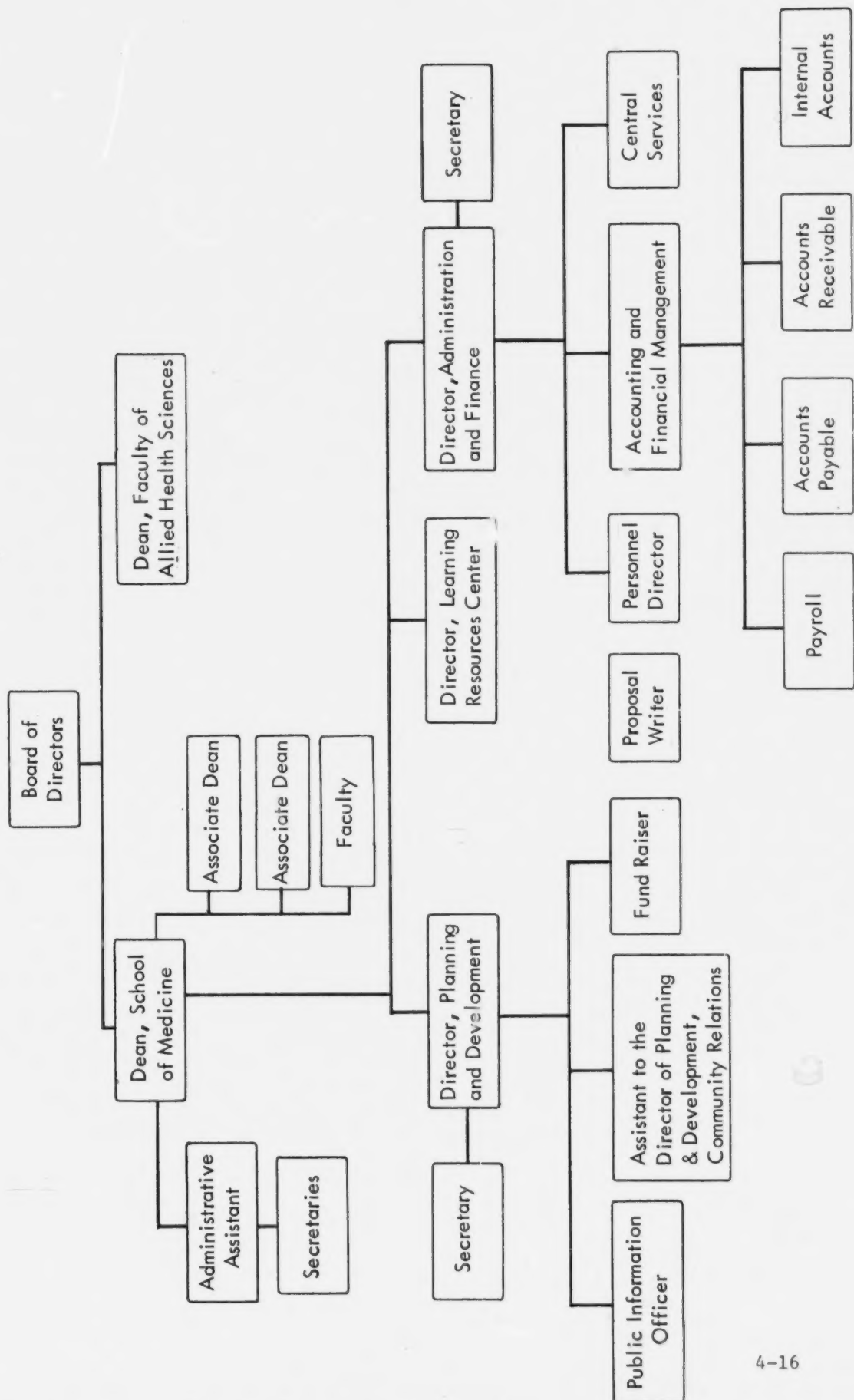
The proposed structure of the office of planning and development would add a total of seven people to the Drew administration, as follows: (1) director of planning and development, (2) fund raiser, (3) community development specialist, (4) two research assistants/grant writers, and (5) two secretaries.

The total salaries for these people would approximate \$120-150,000 which, together with expenses, such as for supplies and services of \$25,000 per year, bring the total for this office to \$145-175,000.

In regard to the LRC, the consultants from the National Medical Audio-visual Center estimated that a staff of about 15 to 20 professionals and support staff would be required, generating salaries in excess of \$200,000 a year.

Figure 3

PROPOSED ADMINISTRATIVE ORGANIZATION, SHORT TERM



4.4 ORGANIZATIONAL RELATIONSHIPS OF THE PROSPECTIVE FACULTY OF ALLIED HEALTH SCIENCES

Plans for a faculty of Allied Health Sciences have been developed under a separate contract with the Bureau of Health Manpower Education. A committee made up of board, faculty, and community residents is searching for a dean.

Allied health training is of great concern and interest to residents of the King-Drew service area. Community residents have understandably insisted that the dean of the allied health faculty be in close sympathy with their interests and that the prospective school of allied health profession training gear its program directly to community needs and concerns. Allied health training will, it is expected, affect community residents more directly than many of the medical school's programs by providing undergraduate and vocational training to persons who are currently untrained.

It is understandable, then, why pressure was brought to bear on the board of directors to have the dean of the faculty of allied health report directly to the Drew School's board, making, in effect, a separate school from the school of medicine.

In terms of day-to-day operation, however, the administrations of the medical school and the school of allied health must work very closely together. Moreover, the faculty and facilities of the school of medicine will probably be used extensively by the school of allied health.

This problem can best be solved by putting into effect the earlier long-term recommendations that the office of a chief executive officer be created to whom both deans would be responsible.

5: Resources

5. RESOURCES

5.1 INTRODUCTION AND DEFINITION OF TERMS

In this section, we will propose and discuss recommendations directed toward the orderly physical development of the Drew School.

The first sections set forth in both narrative and graphic terms a physical planning system within which the definition and planning of each building element can most effectively take place. The discussion includes considerations of the Drew site and provisions for future expansion.

Individual program elements are then described in as much detail as can be justified at the present stage of planning. The assumptions on which estimates have been made are spelled out, the function of the element, its relationships to other elements are discussed, and estimates are made of the areas required to perform the desired functions. The program elements which make up the proposed development program include the Learning Resources Center, School Administrative Offices, Instructional Facilities for Allied Health Professions, a Child Care Center, an Ambulatory Care Center, a Continuing Education Center, an Auditorium, Basic Sciences Research Laboratories, Instructional Facilities for an Undergraduate Medical Curriculum, and a Services Unit.

The physical development program has been conceived as a six-phase program. These phases are not intended to imply separate and discrete construction phases tied to a specific time frame. They simply represent our assessment of the priority of need for these facilities.

In addition, estimates of the personnel who will be housed in these facilities and who will participate in carrying out the various programs of the Drew School are tabulated by category (faculty, administrative staff, technicians, etc.) and by the facility where they will be principally based.

Cost estimates will be found in Section 5.7--CONSTRUCTION AND PROJECT COST ESTIMATES.

Many terms in common use in medical schools vary in meaning from locality to locality, and sometimes vary within one institution. In addition, some of the terms used by the consultant have specific meanings which may not be generally familiar to many readers of this report. The following definitions are of terms used in this and the following sections of this report.

Full Time Faculty:	Faculty members devoting all of their time to teaching, research, and/or patient care and service responsibilities and whose income comes solely from their services at MLK-Drew.
Part Time Faculty:	Faculty members devoting less than 100% of their time to MLK-Drew responsibilities and who do not derive 100% of their income from MLK-Drew sources.
Full Time Equivalent Faculty (FTE):	Part time faculty members converted to the equivalent of full time faculty on the basis of the percentage of time devoted to MLK-Drew programs. For example, two part time faculty each devoting 50% of his time to such programs would equal one FTE faculty, or five faculty each devoting 20% of his time equal one FTE faculty. (Obviously, one full time faculty member equals one FTE.)
Program Element:	An identifiable grouping of related spaces or rooms having similar requirements and functions or of spaces which must function together. It does not imply that separate or individual buildings are required. When facilities are constructed, more than one program element may be combined into a single building, or portions of a program element may be divided between buildings according to specific program requirements, or phases.
Net Square Feet (NSF):	The interior floor area of a building that is directly assignable to a program element; i.e., directly usable for an activity, such as classroom instruction, laboratory research, study, or patient care. It does not include corridors, public facilities such as lobbies or toilets, structural elements, or mechanical areas, stairs, or elevators.
Gross Square Feet (GSF):	The total square foot area of a structure within the outside walls, including all elements within the periphery of the building. The gross area includes the building structure, interior walls, all assignable areas, and all spaces such as corridors, stairways, lobbies, telephone booths, etc.
Building Efficiency:	A measure of the relationship of net or usable space to the gross building area, as defined above. Buildings designed to house different functions vary in their efficiency. In preparing the space estimates in this report, efficiency factors based on generally accepted design standards were used. Building efficiency can be affected to some extent by architectural and design decisions. In the cost estimates building efficiency is expressed as net-to-gross factor. (See definitions below.)

Net-to-Gross Ratio: A percentage indicating the efficiency of a building. For example, a structure of 10,000 assignable and 20,000 gross square feet is 50% efficient.

Net-to-Gross Factor: A multiplier for converting assignable square feet to gross square feet, obtained by dividing the net-to-gross ratio into the number 1. In the above example, $1 \div .50 = 2.00$. The lower the factor, the greater the efficiency of the building. Although not intended to be final, these factors are based on generally accepted standards for the various types of areas and on our experience. As the program becomes more specific and the definitions of spaces better established, the factors may be adjusted.

Construction Cost: Construction cost estimates include the following items: building structure, mechanical, electrical and other utility systems, fixed equipment, and finishing. Construction cost estimates reflect costs in the Los Angeles area.

Project Cost: Project cost estimates are comprised of construction cost plus site work (including utilities connections within the building site only); construction bonds; contingency allowance; architects, engineers, and consultants fees; insurance; supervision; and movable and scientific equipment. $\text{Project Cost} = \text{Construction Cost} \times \text{Project Factor}$. (See below.)

Project Factor: This is a mathematical factor based on the relationship of construction cost to project cost (to include the project costs cited above). A project factor of 1.35 has been used in the project cost estimates in Section 5.7.

5.2 A PHYSICAL DEVELOPMENT SYSTEM

The programs undertaken by the Drew School are likely to be in a constant state of development and change. Yet these programs need a home in the sense of physical space or buildings to house people and their activities. The traditional planning process calls for the sequential definition of program activities, the people who will perform them, and only then arrives at plans for appropriate space designed to house people and their activities. The net result of such sequential planning of facilities has all too frequently been space lacking both flexibility for change and expandability for growth.

In this context, it is perhaps fortunate that the Drew School's programs lack sufficient definition to literally cast them into concrete. It forces us to approach the planning of a home for the Drew School from a very different direction by abstracting those common elements which all present and potential programs will need for their support and to plan for them in such a way that the space can respond to future development, reevaluation, expansion, and change as the school itself responds to changing needs.

This constitutes the rationale for arriving at a physical development system, rather than a traditional master plan with discrete buildings designed to house specified and clearly defined activities. The latter assumes that the future can be known to a degree of detail that the former recognizes is not possible. The Drew School does not aspire to be rigidly locked into programs that may not be relevant in the future; consequently, it should not be rigidly locked into buildings that may not be useful in the years ahead.

The more specifically any plan attempts to dictate long term conditions, the more short-lived will be its utility. Drew's development plan must be continually reviewed and modified; more important, Drew's plan must be a general framework for flexible development, not a fixed pattern of precast conditions. It must recognize not only the fact of change, but allow for varying kinds and degrees of change.

Traditional medical center campus planning follows a rigid, however logical, sequence. First a program of education, research, and care is specified and quantified. Then these measurable elements are identified as discrete buildings with known or assumed configurations. A specific territory is delimited and patterns of access established. Buildings are then disposed over this campus in accord with a general scheme of development, reflecting arbitrary assumptions of aesthetic criteria (ground coverage, floor area ratios, etc.) or real requirements for functional proximity. Streets, parking, plazas, and other amenities are added last to produce the "master plan."

Problems immediately follow the publication of this type of "master plan." The actual architectural configurations do not and cannot conform to those assumed, a change in one forcing subsequent changes in all. Buildings emerge with new components, requiring changes in functional relations. The now superseded plan is followed by another and another, each attempting to keep up with a built environment it can influence only in increasingly insignificant detail. The "master plan" is determined by, rather than determines, campus development. And it is valued accordingly, for its incidental virtues of publicity or fund raising, rather than its real influence on facility growth.

A significant part of our distinction between a "master plan" and a development plan is clearly establishing what any plan can and cannot do, what it should and should not attempt to do. Too much of what cannot be done was normally expected of the traditional campus plan and too much of what could be expected was excluded. The objective should not be to detail a specific environment but rather to provide an organization capable of supporting a variety of environments.

It should be emphasized that the program elements assumed here are preliminary. What is of value to Drew is the planning procedure that underlies them. This document will have served its purpose if it helps to provide the Drew School with a method for doing its own continued planning on its own terms.

To achieve a development system rather than a master plan requires a concentration on the performance specifications of the character, rather than the configuration, of future construction, and distinguishes both fixed and flexible components of campus expansion.

The recommended fixed components of the MLK-Drew complex are the emergency, outpatient, public, visitor, staff, utilities, services, and parking circulations. These are the accesses or networks that organize and regulate existing and proposed campus construction. The recommended flexible components of the development system are the buildings themselves.

In order to provide flexible facilities, a modular discipline of programming and planning is recommended. Compatible with both the site itself and fixed components of access and circulation patterns, we have used as a "building block" a basic module of 10,000 net square feet (NSF) of assignable space. Building blocks of this size can be paired, stacked, or otherwise combined to form larger spaces and can be grouped and assembled to form buildings or complexes. The projections used in this program for each element are based largely on this module. A further advantage of the modular discipline lies in the ability to add on additional modules as programs expand, more space is needed and capital funds become available. The question of scale is also important. Schemes which rely on large phases or extensive construction are clearly unrealistic for Drew. The development plan, using these relatively small program modules, is a

means of achieving facilities which are sequentially buildable on a modest scale.

It should be stressed that program elements do not imply separate or individual buildings. They are defined as groupings of related spaces, rooms having similar requirements or functions, or areas which are dependent upon each other and must work together.

The program elements projected in this physical development system are: the Learning Resources Center (including a biomedical library), the Drew School Administration Unit, Instructional Facilities (for Allied Health Professions), Child Care Center, Ambulatory Care Center, Continuing Education Center, Auditorium, Other Research Laboratories (principally for the basic sciences), Instructional Facilities (for undergraduate medical program), and a Supporting Services Unit. Diagram #1 shows the site of the MLK-Drew complex and the various functional areas recommended for patient care facilities, academic facilities, and support services.

As stated, we recommend that the components of the circulation network for the MLK-Drew complex be considered the fixed elements of its development plan and that rights-of-way for the various kinds of circulation be the fixed framework for future growth. As a general rule, this network should not be changed and buildings should be designed to respect, not alter, these routes. These are the skeleton of the complex and can assure that proposed and existing construction is coordinated in each building phase.

Diagram #2 illustrates these MLK-Drew circulations which constitute the fixed basis of the development system. The pattern shown is determined by the master plan for the MLK site; no substantial change in this plan is required for adoption of the system other than the extension of current pathways. The kinds of circulations illustrated are: emergency access, staff circulation, visitor and public access, outpatient access, service access, utilities distributions and parking.

The practical necessity to make maximum use of available land and limit additional acquisition presupposes parking structures. Parking demand can be measured only as programs are defined and populations projected. Policy decisions must be made as to what percentage of the peak demands will be satisfied on site. Nonetheless, parking is the largest land consumer. Together with the obvious advantages of safety, convenience and aesthetics, structured parking conserves land. It is, however, more expensive than surface parking and the economics of structured parking should be evaluated in terms of peak demands, user fees, land acquisition and the availability of practical alternatives. Recognizing the cost and complications of parking below buildings (or designing garages to take other construction above them) the plan assumes provision of independent parking structures. However, the desirability of multiple land use may warrant reconsideration of this assumption. In any case,

careful attention must be given to the scale, location, and design of the medical center's garages so that they are not allowed to dominate the whole complex.

To reduce this bulk and increase their utility, these structures could be partially or wholly below grade, maintaining a low profile; their roofs could be landscaped as recreation areas or decks to recapture the site for pedestrian use and preserve the amenities of open space.

"Buildings" of the medical center should be thought of as increments of flexible space plugged into the fixed circulation framework. These increments are flexible in two senses; their configurations can be independent of one another; their phasing sequences can change. As these increments are built, adjacent portions of the fixed circulation framework would be extended to attach them to the total complex.

The configuration of these buildings is of little concern to the development plan. They should be modular, respect the circulations fixed by the plan and they could be further restricted by the aesthetic objectives of the whole campus. One characteristic of all these increments is of paramount concern: their flexibility. Each should be capable of withstanding change. Generally, individual buildings specifically tailored to a particular program or set of physical requirements should be avoided in favor of modular facilities capable of multiple use. Not all the space must be uniform nor specific requirements for unique facilities (e.g., an auditorium) avoided altogether. But most space should, in our judgment, be designed with the following factors foremost in mind:

1. Extensive floor areas proportioned to allow alternative layouts without depending upon fixed internal hallways. Long, narrow structures with a fixed central corridor, for example, have limited utility; irregularly contoured buildings restrict internal rearrangement.
2. Long or clear span structures to reduce the number of columns on the floors. Small or poorly proportioned bays and short spans require a forest of columns that constricts internal arrangements. Obviously structural cost is a major consideration; but it is not the case that longer spans and modular systems are by definition more expensive, or even as expensive, as original or poured-in-place construction. Over the life of a typical building, construction cost is negligible compared to the annual operating expense. Real economics of facility construction do not lie in purchasing the highest operating expense at the least initial price.
3. Adequate floor-to-floor heights to allow installation, repair and replacement of utilities. The density (i.e., number, size, and complexity) of these services for medical facilities is

great and increasing. Space above the ceiling should be deep enough to house installed equipment and leave room for new equipment or unknown systems. These fixtures should be carefully integrated with the structure and ample area left for re-routing them to serve re-arranged functions on the floor. A major factor in facility utilization is the "down time" of that space caused by the inconvenience to, if not disruption of, continued operations for maintenance of equipment. Where this is a factor, as well as more extreme density of service, provision of interstitial spaces (i.e., full headroom mechanical areas between the floors for independent service access) is advisable. Again it is not the case that interstitial spaces, or sufficient structural/mechanical space between the floors, automatically increase construction cost or constitute unacceptable increases in this cost. Added expense, if any, is a function of structural design or materials and is insignificant when measured against the life costs of building maintenance.

4. Modular and uniformly subdivisible space within and between buildings to allow expansion and accommodate movable internal wall subsystems. Every effort should be made to gather fixed vertical elements (elevators, stairs, ducts, shafts, fire walls, toilets, etc.) on the peripheries of the floors to maintain the flexibility of the functional areas.
5. Dispersed circulations to avoid concentration of vertical loads at a single point and the congestion or delay that result from mixing different traffic (e.g., staff and supply) at the same point. Major through circulation, horizontal and vertical, should be fixed but minor internal circulations (within a department or functional area) should be changeable. Pedestrian and supply traffic should be organized to further separate public (patient and visitor) from staff (faculty, students, employees) so that activities housed in the buildings are not subjected to disruptive or extraneous through traffic.

These objectives are illustrated by the modular development of the Drew School shown in Diagrams #3 and #4. This linear campus is connected by bridges across 120th Street to MLK Hospital and could be built in phases to both the east and west of its first stage and central facility: a learning resources center.

Diagram #4 details one approach to design development of a typical building using this modular system. A portion of the fixed peripheral corridor framework is shown surrounding two typical building blocks. The internal areas of these blocks are subdivided into two zones. Common zones group such fixed elements as stairs, elevators, mechanical ducts, shafts, public toilets, et al., in a single area along the peripheral corridors. Functional zones are flexible proprietary spaces available for

multiple use, relatively free of structural constraints and through circulation. As the campus is built, a variety of internal spaces and exterior courtyards could be created using the vocabulary of fixed and flexible elements that comprise the Drew School development system.

Diagrams #1 through #4 constitute the Drew development system. This proposal must be regarded as a preliminary statement of intent and should be subject to continued and critical evaluation. The diagrams suggest (#1) a medical center site and generalized land use; (#2) a fixed framework of circulation and access to serve those uses; (#3 and #4) an illustration of modular development of the Drew School suggesting a location for the learning resources center.

The indeterminate nature of the Drew program and adoption of such a development system offer potentially significant savings in construction time and dollars because they form a ready basis for fast-track programming and design, systems building, and other contemporary techniques that promise more efficient space, more rapid construction, and more economical cost.

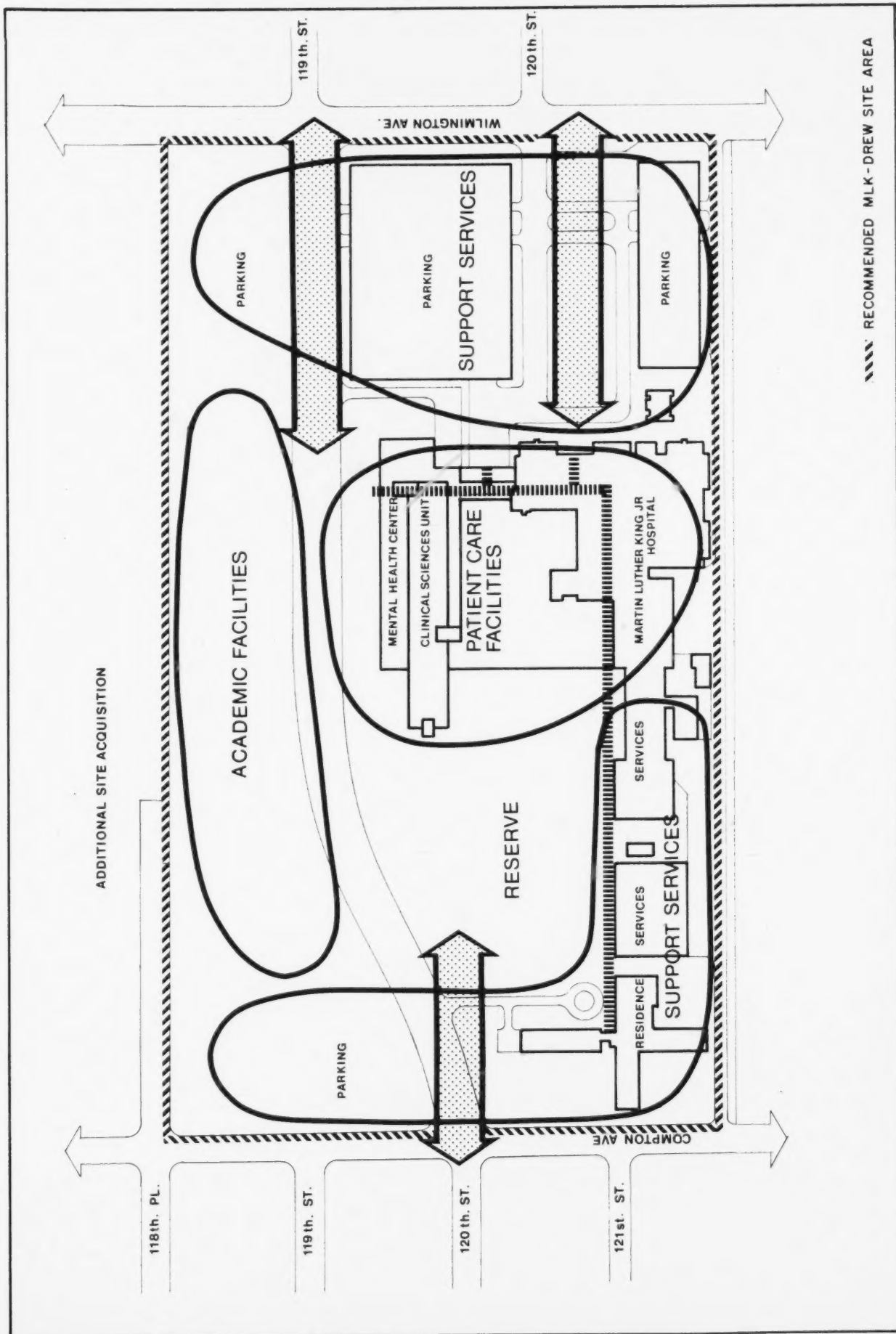
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Diagram #1: MLK-Drew medical complex study area
Land use functional zoning

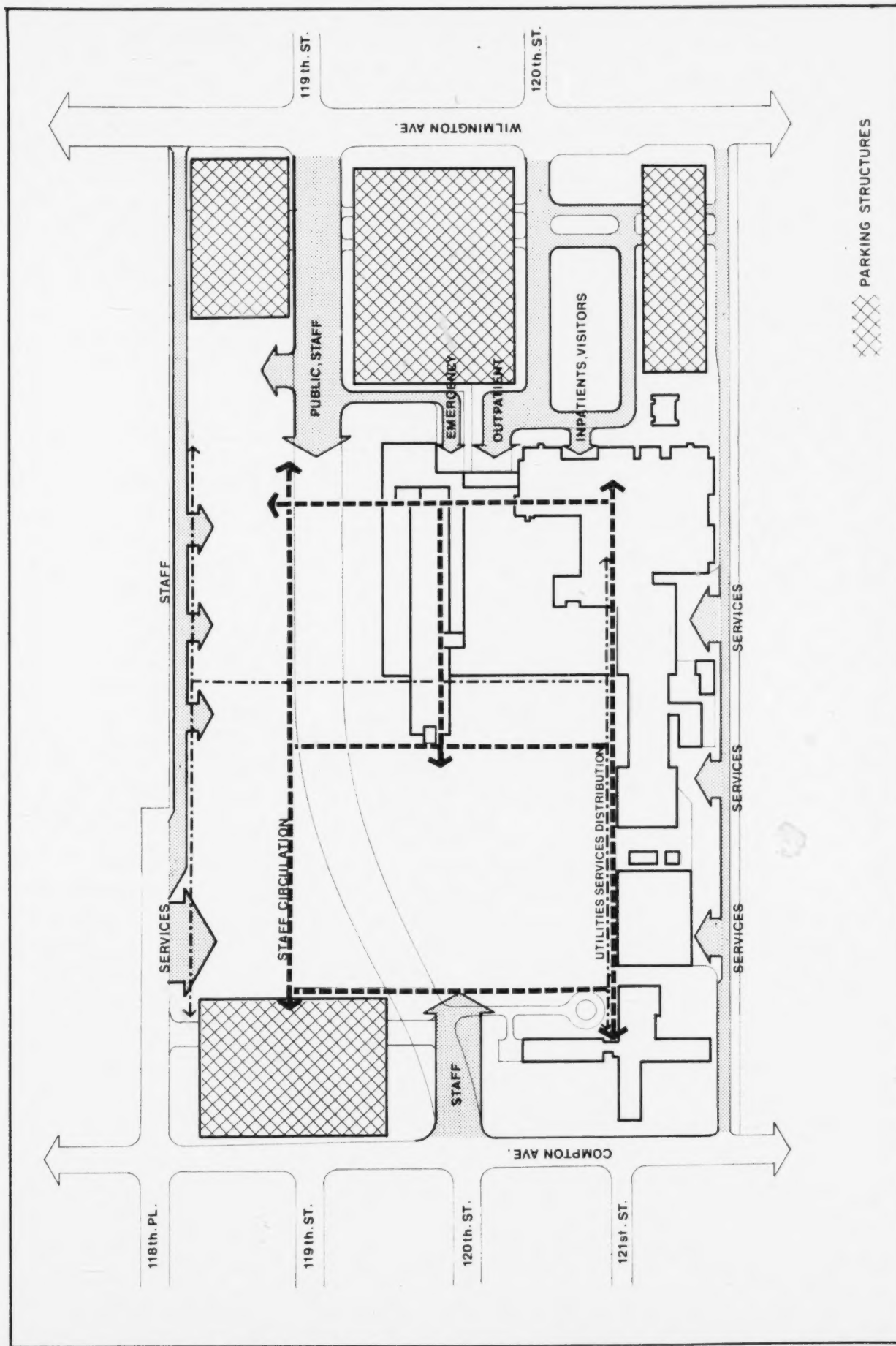
Diagram #2: Fixed development plan components
On-site circulations and access

Diagram #3: Flexible development plan components
Modular building increments

Diagram #4: Flexible development plan components
Modular building zones



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A DEVELOPMENT SYSTEM FOR THE DREW SCHOOL

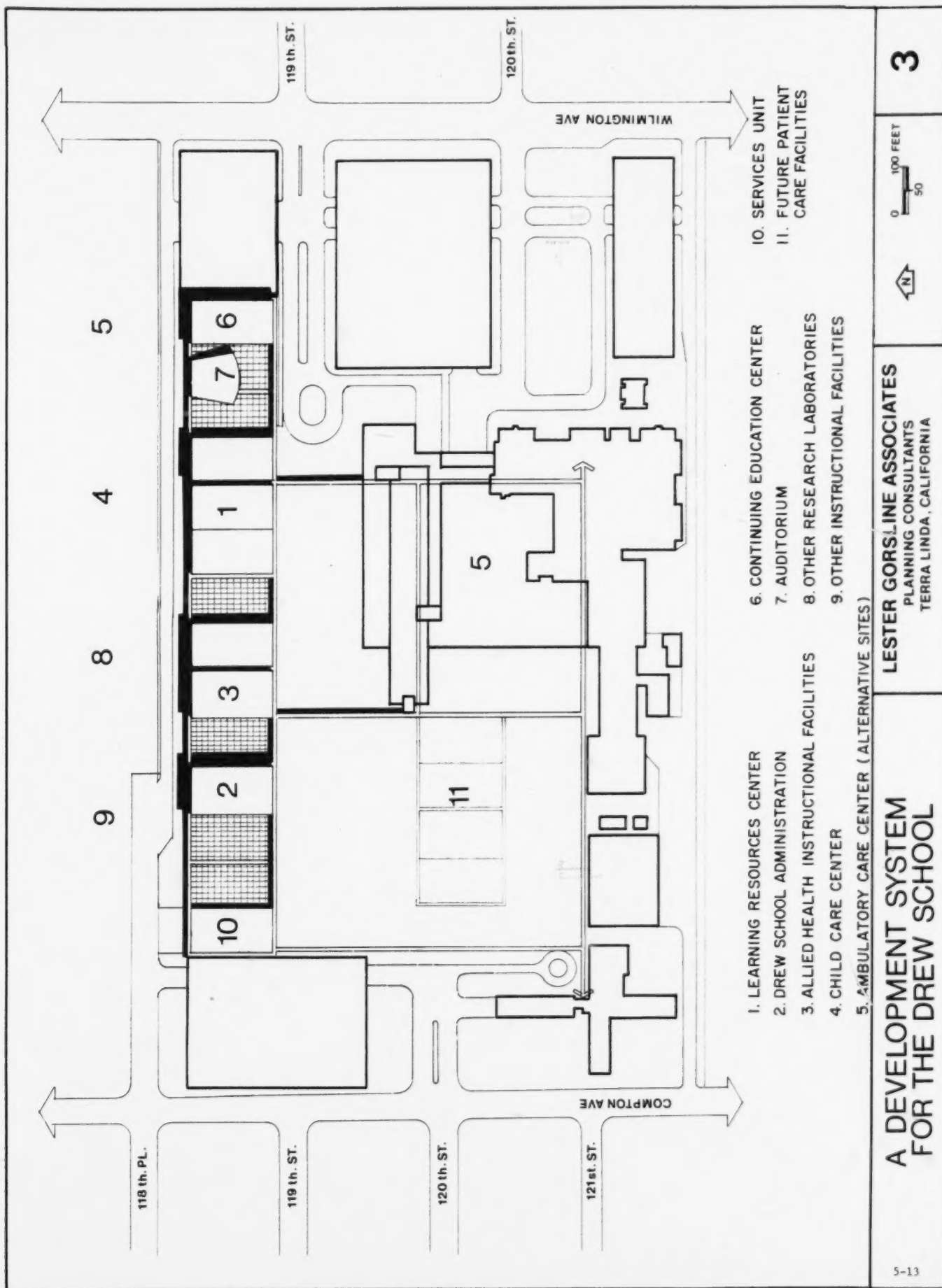
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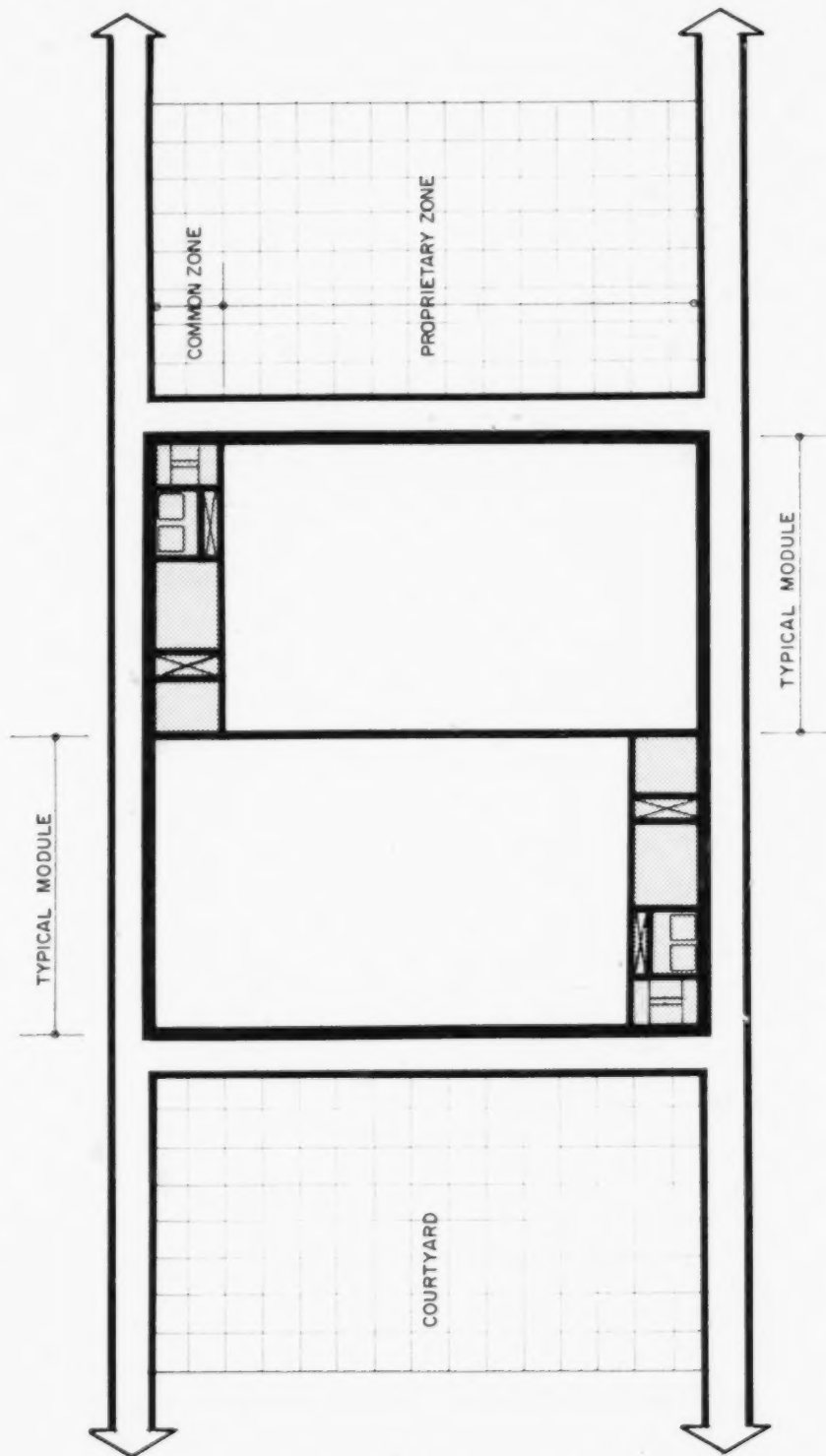
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PARKING STRUCTURES





A DEVELOPMENT SYSTEM FOR THE DREW SCHOOL

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5.3 SITE CONSIDERATIONS

We have chosen to view the proposed site as an integrated campus composed of closely related functions rather than as two separate entities: Martin Luther King, Jr., General Hospital and Drew Postgraduate Medical School. We strongly recommend that both future program planning and future physical planning be conducted as a joint effort by King Hospital and Drew School to achieve the development of a cohesive medical center. Inasmuch as these two institutions must function together as a whole complex in order to achieve their respective and shared goals, their physical facilities and the land they occupy must also be viewed as a whole. Further assumptions which underlie the recommendations in this section are that the Drew School construction should be guided by a development system such as is proposed in Section 5.2 above, and that the program for Drew's ultimate development will approximate the elements forecast in Section 5.5 below.

The total site area under consideration is bounded by Wilmington Avenue on the east, Compton Avenue on the west, the existing boundary (service road) just north of 122nd Street on the south and 118th Street on the north. It is the section of the site from 120th Street north to 118th Street that will most concern the Drew School, as not all of it is presently owned or controlled by Los Angeles County.

During the progress of this Master Plan Study, we analyzed those programs currently under way by the Drew School and those under consideration for both short range and long range implementation. We then projected estimates of the facilities or buildings which would be needed to house these programs (see Section 5.5). This exercise has resulted in a potential need at full development of the school for almost 300,000 net square feet of space and just over 500,000 gross square feet of buildings which the campus site may have to accommodate ultimately. Accordingly, our recommendations to the Drew School for land acquisition fall into short range and long range considerations.

For those facilities we have forecast as needed in the near future by the Drew School (short of what is required to support undergraduate medical education in the basic sciences and exclusive of the Ambulatory Care Center) less land will be required, of course. To accommodate those program elements, namely, the Learning Resources Center, Administration Unit and Community Medicine, the Allied Health Sciences Instructional Facilities, the Continuing Education Center, Auditorium, and the Service Unit, we recommend that steps be taken now to acquire the entire area bounded by Compton Avenue on the west, Wilmington Avenue on the east, re-located 120th Street on the south and on the north up to a line extending and approximating the southern edge of the right-of-way of 118th Place. These elements total 142,000 NSF and approximately 273,000 GSF and include the Phase VI additions to Administration, the Learning Resources Center and the Service Unit.

If this Drew program is expanded to provide undergraduate medical education facilities for the basic sciences (the labs and instructional facilities of Phase VI) this site area should be increased by further acquisition to provide a campus bounded on the east by Wilmington Avenue, on the south by 120th Street, on the west by Compton Avenue and on the north by 118th Street. This additional acquisition will be needed to accommodate the long range program in basic sciences education which totals an estimated 85,000 NSF and 153,000 GSF. Ideally, these elements should be located close to the Clinical Sciences Facility to be built adjacent to MLK Hospital, both to assure close working relationships between basic and clinical faculty and because the basic sciences facilities will be dependent upon experimental animal quarters located in the Clinical Sciences Building. In addition, the basic sciences elements can be expected to provide space for the added clinical faculty required for the undergraduate medical education program for whom space may not be adequate in the Clinical Sciences Facility. However, since these program elements are assumed to be developed last, and in fact may never be built at all, their ultimate location is of less concern than the location of more immediately needed Drew School facilities. Considerations of siting and cost, to name only two, move us to recommend that the Drew School assign the lowest priority to the development of an undergraduate medical education program in the preclinical years, and move in such a direction only after very careful analysis, if at all.

It should be noted that the Drew School is currently negotiating for approximately two acres in this area north of 118th Place as a site for the Child Care Center. This land will be purchased in the name of the Economic Resources Corporation who will construct the Child Care Facility on it and lease it back to the Drew School. While we are indeed aware of Drew's eagerness to get this program started, we urge that the school give careful consideration to the long range implications of this method of financing and this location for the Child Care Center to be sure that future site options are not impeded by this move.

Diagram #5 immediately following this section illustrates both our short and long range site acquisition recommendations as well as the presently intended site of the Child Care Center.

The reader will recall that in the preceding section on the Physical Development System, we recommended the creation of functional zones for the principal activities of patient care, academic activities and supporting services, leaving a sizable reserve area in the center of the site. (See Diagram #1, above.)

Patient care facilities, with the probable exception of the ambulatory care center, are concentrated in the center of the site to allow the largest number of other services and facilities to be related to them. Patient care facilities include the hospital, the mental health center, and the clinical sciences unit. Supporting services are located on the east and west sides of these central facilities, with service access from the south. Residences, services, and parking constitute these services. Academic facilities are located north of 120th Street.

We have been of two minds in regard to the siting of the ambulatory care center. If economic and logistic considerations were to prevail, it should be located contiguous to the hospital, whose support services it would share. A stronger consideration exists, however, in the necessity of maintaining the administrative independence of the center. This, we judge, calls for physical separation also. We have, consequently, indicated alternative sites for the ambulatory care center.

The resulting on-site network of circulations and services was illustrated by Diagram #2, above. We recommend that this network be the basis for designation of building sites and configurations of phased campus construction. This network is an extension of the present spine. The network could be composed of external walks, bridges, internal corridors, elevators, and stairs at appropriate levels to connect the entire complex. Utility distribution extends the present tunnel to service new academic and patient care facilities.

Much of the site now owned by the County and designated for the Drew School is used for parking. This parking could be displaced by construction of the proposed County structure at 120th Street and Wilmington Avenue. However, additional land must be acquired, as noted above, to support campus growth as the presently owned land is too narrow and poorly proportioned.

When parking requirements for the Drew School facilities are added to the construction projected for the area up to 118th Place, the following conditions must be given careful consideration:

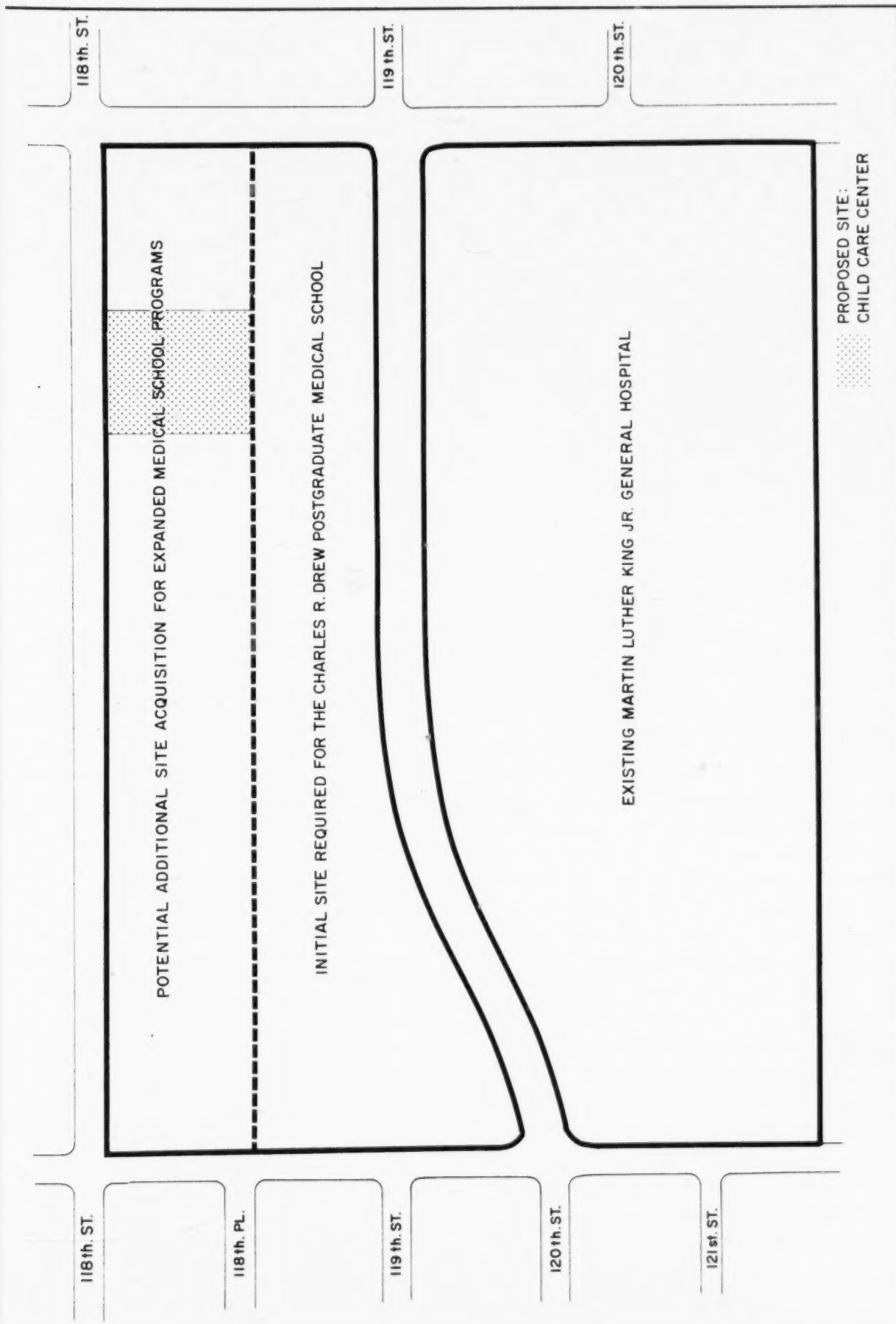
1. The density of development could be high. Assuming continuation of a low rise development as proposed by the system described in Section 5.2, ground coverage of the site by buildings could be higher than is usual for campus development. By itself this is not an unacceptable nor necessarily undesirable condition; it merely emphasizes the necessity for sensitive building and site design, pointing up the need for an integrated, modular concept.

2. Toward the eastern end of the site the campus narrows to a constricted width of about 210 feet. The recommended development system (Diagram #3) recognizes this restriction.
3. Acquisition up to 118th Place provides a site with little or no public access along its northern border. Service and staff access could be provided in the same manner as along the present southern border of MLK Hospital. The recommended plan does not require the vacation of 120th Street. However, given both the recommended consolidation of MLK inpatient and outpatient access and the development of Drew staff/service access along its northern border, vacation of at least the central portion of this paving would integrate the total development, improve site circulation, and provide landscaping and open space. The 120th Street right-of-way could be retained as an emergency vehicle and utility easement.

Designation of an MLK-Drew urban renewal area provides an opportunity to verify these long term site needs. If both the Century and Industrial freeways are built as planned, the area within their rights-of-way and those of Compton Avenue and 122nd Street would encompass 130-140 acres. The long term renewal of this area is of interest to the medical center. Land east of Wilmington to the Industrial freeway could be a logical site for medical/commercial facilities and high density housing. Attention should be paid to the low-density housing along Compton and 122nd Streets. MLK-Drew will have a deleterious effect on this boundary and, as a transition area from medical center to community scale, its composition will be a continuing concern.

The urban renewal plan, as well as MLK-Drew facility needs, should influence long term use of the area from MLK-Drew north to the proposed Century freeway. The medical center program as currently foreseen is, in our opinion, an adequate justification for site acquisition north to 118th Place. The justification for further northern expansion of the Drew campus to 118th Street must be a substantial increase in the school's program; i.e., the addition of the undergraduate basic sciences elements. However, this justification could be influenced by determination of the future of the housing retained between the medical center and the freeway, the future of the Lincoln Elementary School and future needs for other community facilities for which this could be a desirable site.

We recognize that the acquisition of any additional land by the Drew School will pose the difficult problem of what happens to the people now living there, particularly since the surrounding area is residential, principally small, single-family houses. Relocation of residents has frequently been a knotty problem in the redevelopment of urban land and the Drew School must recognize its role in this respect. In consideration of this and other factors, we recommend that the school take steps now to acquire the land up to 118th Place with further expansion north to 118th Street reserved until such time as and if the undergraduate medical school program is warranted.



A DEVELOPMENT SYSTEM FOR THE DREW SCHOOL

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5.4 DISCUSSION OF PHASED DEVELOPMENT

It will be recalled that we have recommended a six-phase development program for the facilities projected here. However, we want to stress again that these should not be construed as six separate or discrete construction phases. The facilities in each phase represent our assignment of the priority order in which the academic programs to be housed in these facilities should be developed. If sufficient capital funds were available, for example, we would like to see Phases I through IV (or even I through V) all built in one construction phase, as the programs these facilities will support are of the highest priority in our view. Further, we believe it is mandatory for the Drew School to develop initially and continue to conduct programs out in the community, using off-site facilities and locating programs out where the need exists. In this view the facilities on the MLK-Drew campus act as specialized central support for a network of program activities rather than as a free-standing center unconnected to its surroundings.

Clearly, the highest priority programs for the Drew School are in the areas of allied health professions training, consumer education, continuing education for local health care providers and programs in ambulatory patient care. We recommend against the development of undergraduate medical education in the basic sciences because of both its high cost and its low impact on the needs of the service area.

Phase I totals 70,000 net square feet (NSF) and includes a core of facilities for the Drew School. Provided are the Learning Resources Center, an administrative unit to house the school's administrative officers and staff, offices and support space for the department of Community Medicine and a small services unit to provide shipping, receiving, storage, transshipment areas as well as space for building and grounds maintenance staff and equipment.

Space estimates for Phase I facilities rest on several basic assumptions. No space for faculty other than the department of Community Medicine has been included on the premise that these people will be housed in the Clinical Sciences Building to be provided by Los Angeles County and to be located adjacent to the Martin Luther King, Jr., General Hospital. Although some instructional spaces, such as seminar and classrooms as well as self-instructional carrel areas, are included in the Learning Resources Center, it has been assumed that most instruction of interns, residents and students in Drew's Allied Health Professions programs will take place in the hospital and the Consortium Colleges for the immediately foreseeable future. The same will be true of initial programs mounted by the Drew School in the areas of continuing education and consumer health education. The Learning Resources Center provides a core which can be added to in the future as developing programs place increased demands on this supporting facility. Included in Phase I are production areas in the various media,

a library housing those most recent and most used volumes to support postgraduate clinical programs, Allied Health Professions, and research needs of the clinical faculty. This core collection is based on the assumption that older and lesser-used journals and monographs can be quickly obtained from other sources (such as USC, UCLA and the Regional Medical Library) in the Los Angeles area through inter-library loans and other means. The Learning Resources Center also includes public areas and will support programs in consumer health education, both through its own efforts in its own facilities and through coordination with schools, libraries, cultural centers, churches and other hospitals (including MLK) in the community.

Phase II adds one very basic and critical element to the above facilities, i.e., 30,000 NSF devoted to instructional facilities for programs in the Allied Health Professions. This space will include seminar and classrooms as well as some student teaching laboratories. Offices for Allied Health Professions faculty not housed in MLK Hospital will also be located here.

This element has been designated a Phase II facility because we believe that the development of a variety of such training programs represents both an area of critical need and visible impact for the Drew School and should not be delayed. We have assumed that these programs can be started using space provided in the MLK Hospital, the Learning Resources Center, and off-site institutions such as the Consortium Colleges, but that very quickly they will (and should) expand to the point where enlarged and additional central support space will be needed for them.

Phase III and Phase IV consist of 30,000 NSF for the Child Care Center and 40,000 NSF devoted to an Ambulatory Care Center, respectively. Priority or phase designations between these two structures are somewhat arbitrary in our view. Which actually is built first will depend upon factors difficult to predict now and include how quickly programs are defined and both construction and operational funds for each can be found. Our impression at this writing is that the Child Care Center is closer to reality in terms of defined programs and potential funds, which explains its Phase III status. Most obviously, both should have a high priority in terms of responding to community need and providing the Drew School with an appropriate and visible identity in the eyes of service area residents.

Phase V adds an auditorium and a Continuing Education Center to the Drew School complex and totals 22,000 NSF. The auditorium will provide seating for approximately 400 persons and will be used by community groups as well as MLK-Drew sponsored programs. The Continuing Education Center will house the staff responsible for organizing and conducting meetings, seminars, symposia, etc., in programs of continuing education aimed at health practitioners in the community. It will provide necessary conference areas, classrooms, meeting and study spaces to supplement those available in the Learning Resources Center. It will also provide limited food

service areas. A small number of hotel-type sleeping rooms may be desirable for persons attending extended programs should space be unavailable in the interns-residents dormitory and if motels are not available in the area near the MLK-Drew complex.

These facilities are designated in Phase V on the assumption that continuing education programs will have outgrown space available in the Learning Resources Center. We concur with the Drew School that these are high priority programs which should be started long before this facility is built, and should continue to be conducted both off-site as well as on-site in these facilities. It is also our belief that with proper coordination and scheduling, these facilities can meet some of the needs of programs in consumer health education and possibly others.

Phase VI covers the addition of an undergraduate medical education program to the Drew School's activities. This phase actually breaks down into three discrete steps, only the last of which involves construction of facilities. The first two steps are developmental and represent our assessment of the most expeditious way of getting into a program of undergraduate medical education, should the Drew School decide to do so.

The first step involves launching clinical programs for undergraduate medical students. This can (and probably will) be done initially through affiliations with UCLA and USC whereby medical students are given clinical education experiences at the MLK-Drew complex. This experience will provide the basis for Drew's becoming a full-fledged clinical campus capable of providing the last two years of medical school and granting the M.D. degree. We have assumed that the latter development (providing clinical-years instruction and granting the degree) will mark the completion of the first developmental step and can be accomplished by adding a minimum of faculty in the clinical disciplines, a small administrative staff and essentially by using existing MLK-Drew facilities, without adding new construction. At this time it is our recommendation that the Drew School not go beyond this point in the area of undergraduate medical education.

Should this recommendation not be adhered to, the following steps would seem to us to be necessary. The second developmental step covers the gearing-up and implementation, on a limited basis, of a program in basic science education for undergraduate medical students. Essentially, this involves planning a curriculum for what has traditionally been the first two years of medical school, adding a core of faculty in the basic sciences and beginning to teach a small (or pilot) entering class of, say, 24 to 36 freshman medical students. It may be possible to do this in existing facilities, or by adding limited pre-fabricated and temporary teaching and research laboratory and office space.

This build-up of an undergraduate medical education program, beginning with clinical programs and then moving into a small program in basic sciences education, is the reverse of the customary way of starting a new

medical school. However, it takes advantage both of existing strengths and facilities available to the Drew School, and recognizes that the development of such a program should occupy a low position among the school's priorities. The question of whether such an undergraduate program should be three or four years has been left open for obvious reasons. Further, by developing the clinical aspects first, we believe that greater attention can be devoted to the degree of integration between these and the basic sciences than would be possible, perhaps, by approaching from the direction of the basic sciences.

The third step of Phase VI covers the expansion of the undergraduate medical education program to an estimated ultimate size of 100 students per class as well as the provision of permanent facilities required to house the program. This will add approximately 30,000 NSF for offices and laboratories needed by basic sciences faculty; an additional 10,000 NSF to the Learning Resources Center to house teaching and research materials required by an undergraduate medical education program; a 5,000 NSF addition to the services unit; and 5,000 NSF more in the school's administrative unit to house such offices as student affairs, medical school admissions, student records, financial assistance and counselling functions. Space to be added in Phase VI to accomplish a full undergraduate medical school program totals 105,000 NSF.

DREW POSTGRADUATE MEDICAL SCHOOL	D E V E L O P M E N T P H A S E S						
	I	II	III	IV	V	VI	
PROGRAM ELEMENT	(All in Net Square Feet)						
Learning Resources Center (Including Biomedical Library)	40,000					10,000	50,000
Drew School Administration and Dept. of Community Medicine	20,000					5,000	25,000
Instructional Facilities (Allied Health Sciences)		30,000					30,000
Child Care Center			30,000				30,000
Ambulatory Care Center				40,000			40,000
Continuing Education Center					15,000		15,000
Auditorium					7,000		7,000
Other Research Laboratories (Principally Basic Sciences)						55,000	55,000
Instructional Facilities (Undergraduate Medicine)						30,000	30,000
Services Unit	10,000					5,000	15,000
TOTAL - Each Phase	70,000	30,000	30,000	40,000	22,000	105,000	
TOTAL - All Phases							297,000

5.5 DESCRIPTIONS OF PROGRAM ELEMENTS

5.5.1 Learning Resources Center

General Function: It has been generally agreed--by the faculty, the Drew School administration, the board of directors, the board of visitors, and the Master Plan Study team--that the first element of the building program should be a learning resources center (LRC). This decision is supported by the contributions the LRC will make to the basic strategies described in Section 2. In particular, the learning resources center is seen as urgently necessary to support Drew's educational programs, which range in sophistication from residency programs and continuing education for physicians to the training of community health workers. Another, and most important, function is that of supporting programs of consumer education and patient education. The Learning Resources Center should operate as a collection of services and personnel supporting all educational programs conducted by the MLK-Drew Center wherever such programs are actually carried out.

Functions to be performed by the Learning Resources Center will include:

1. The development of teaching packages to assist faculty members in developing the means to communicate more effectively with their students, whether these are graduate MD's, allied health workers, or high-school students. This service will include not only the planning of technical support (videotape recording, computer-assisted instruction, etc.) but also assistance in the organization of curriculum materials.
2. A library, which will not only provide the research backup for faculty but also collections appropriate for all the teaching programs to be mounted by Drew. In addition, an important component of the library will be special collections that will comprise a cultural center for the enrichment not only of MLK-Drew personnel and programs but also of the community as a whole.
3. A production component, which may include:
 - a. photography, both still and motion picture;
 - b. graphics and medical illustration;
 - c. videotape recording;
 - d. a radio broadcasting station directed from Drew into the community;
 - e. computer programming services related to the development of learning programs.
4. Learning spaces, which will provide for a variety of teaching-learning functions, including self-study, tutorial study, small-

group study and small-group instruction, and large-group instruction.

Type of Space: In order to support the functions described above, the LRC will include offices for administrative, technical, and professional staff, stacks and storage space for books and media materials, workrooms for the technical processing of books and other materials, production facilities, including studios for photography, cinematography, television, and radio production as well as for medical illustration, sculpture and model making. In addition, the LRC will require reading rooms, exhibit rooms, meeting rooms, large and small classrooms, and learning carrels.

Estimated Size: Total space estimated for this program element is 50,000 net square feet. Of this, we believe 40,000 net square feet should be included in Phase I of the program, with the additional 10,000 net square feet scheduled for Phase VI.

In estimating the initial size of the LRC, we have assumed the following components and areas:

<u>Component</u>	<u>Area NSF</u>
Administration	1,500
Workrooms (library and media)	2,000
Book stacks (50,000 volumes)	5,000
Media material and equipment storage	5,000
Reader service areas	1,000
Library reading rooms	4,000
Production areas:	5,000
Photography and motion picture	
Television and radio	
Medical illustration, sculpture, model-making	
Computer programming	500
Learning spaces:	
Class & meeting rooms	5,000
Conference, seminar, group-study rooms	5,000
Self-learning carrels (50)	2,000
Exhibit & display	2,000
Additional space allotted to cultural enrichment activities	<u>2,000</u>
	40,000

If an undergraduate medical education program in basic sciences is mounted, another increment will have to be added to the LRC to accommodate the requirement both of the medical students and of the basic science faculty. We estimate that this added increment will require approximately 10,000 additional net square feet in Phase VI.

Relationships: The matter of physical and functional relationships between the LRC and other elements of Drew is a crucial one. If the LRC is well-located with regard to the population it serves, it will attract patronage and support. If it is inconvenient to visit, it will remain relatively unused. In locating the LRC, the needs and convenience of the following groups should be considered (the order is not significant):

- a. MLK-Drew faculty and support staff
- b. House staff
- c. Students in allied health programs
- d. Patients
- e. Community health professionals
- f. Community residents in general
- g. Students in the Drew School undergraduate medical curriculum.

Planning Assumptions and Unresolved Questions: Any planning for the LRC that can be done now is necessarily only of an order-of-magnitude precision. More detailed planning should await the appointment of a director of the LRC, whose first undertaking on the job must be to lead the planning effort. Any further work done on the design of the LRC before the director is appointed and comes aboard is premature and probably counter-productive. (This is not to say that Drew faculty and staff should refrain from exploring the literature of the LRC and considering its possible functions at Drew. Basic decisions, such as the degree of decentralization, should not be made, however, in the absence of a director.)

The estimates of required space made above must be considered as representing only one possible configuration of an LRC. The areas allotted to the various components are offered as not-unreasonable estimates. A valid building program can only be developed under the leadership of a competent and experienced director.

In arriving at these preliminary estimates, we have been guided by the following assumptions:

The LRC will serve the entire MLK-Drew complex and not Drew alone. Its mix of services and physical facilities will be generated as a response to the needs of the complex.

Physical facilities are of course necessary, but two other elements are even more important: (1) a commitment on the part of the faculty and staff to support and use the LRC, and (2) adequate financial resources to permit the LRC to deliver services and products that are appropriate both in scope and quality.

We have assumed a fair degree of centralization, but have also assumed that waiting-room and hallway areas in King Hospital will be used for displays and teaching devices for patient education. In this connection, we suggest that when and if King Hospital is expanded,

thought should be given to providing more learning spaces of all kinds rather than more beds.

The library has intentionally been estimated at the low end of the scale, on the assumption that Drew should begin by acquiring only those materials that are needed immediately and needed frequently. For less urgently needed books and journals, Drew must arrange to draw on the other medical school libraries, the regional medical library, and services provided by the National Library of Medicine. If basic scientists are added to the faculty, an addition to the library will be required.

Among the questions which remain to be resolved are:

What will be the balance of centralized and decentralized LRC functions? What elements should be decentralized? In what ways will the LRC reach into the hospital and into the community?

With regard to the size of the library and the services it will offer, is it realistic to assume that a substantial part of MLK-Drew's needs can be met by cooperative arrangements, inter-library loans, and such devices as rapid messenger services?

What activities are foreseen for the "cultural component?" Will this be health-oriented or not? Will it include, at the LRC, such activities as art shows, concerts, lectures, movies?

5.5.2 Drew School Administration Unit

General Function: The function of this program element is to provide space to house the deans and administrative officers of the Drew School as well as the department of Community Medicine. Included will be the dean of the Drew School, the dean of Allied Health Professions, the Office of Planning and Development, and the director and staff of the Office of Administration and Finance with the related functions of accounting, purchasing, personnel, grants and contracts management. Student records, admissions, registrar's office, student affairs, public relations and all other administrative functions will be based in this program element. The space allocated the department of Community Medicine will consist largely of departmental and faculty offices.

Type of Space: Administrative activities require executive and secretarial offices, general work areas, storage rooms, conference rooms, duplicating and mail distribution work rooms as well as reception and waiting areas. An area housing data processing equipment may also be required for accounting and business office functions.

Estimated Size: 25,000 net square feet (Phase I, 20,000; Phase VI, 5,000)

Relationships: The school's administrative offices should occupy a location providing convenient access to faculty, students, and other school personnel. Equally important is an easily recognizable access for visitors and for community residents. The same considerations are valid for the department of Community Medicine.

Planning Assumptions and Unresolved Questions: We have assumed a phased schedule for this program element. The Phase I allocation of 20,000 net square feet provides space for Community Medicine (5000 net square feet) and all of the school's central administrative staff, including those associated with the Allied Health Professions. This is believed to be sufficient until such time as an undergraduate medical curriculum is added to the school's programs. If this occurs, an added increment of 5000 net square feet will be needed to house associate deans, student affairs offices, admissions, and additional student records connected with such a program. This increment is scheduled as a part of the last phase (Phase VI) in the projected development of the Drew School.

5.5.3 Services Unit

General Function: This unit will provide locations for receiving, storage, and transshipment of equipment, materials, and supplies used by the Drew School. Some shop services for equipment maintenance and building maintenance will also be included along with offices for plant engineering, security, and materials management personnel. Storage areas will be needed for building and grounds maintenance equipment.

Type of Space: This program element will consist of a shipping/receiving/storage area with truck loading dock, shop areas such as carpentry, painting, metal work, and equipment repair and maintenance, locker rooms for maintenance staff and some administrative and clerical offices for supervisory personnel.

Estimated Size: 15,000 net square feet (Phase I, 10,000 NSF; Phase VI, 5,000 NSF)

Relationships: No particularly strong physical relationships exist for this program element beyond a location which will ease distribution of materials from the receiving point. In fact, some functions assigned to this element may be dispersed as appropriate throughout other facilities of the Drew School.

Planning Assumptions and Unresolved Questions: The estimates for this element assume that these services will not be supplied by King Hospital. If the hospital can supply some or all of these services at the time they are needed, the estimates can be revised downward. The space allocation in this Services Unit has been divided between two phases. We have assumed that more than half of this space will be needed to support the activities associated with Phase I of Drew's development schedule; i.e., the Learning Resources Center and Administrative Unit. The balance of the space allocated to the Services Unit is planned for Phase VI on the assumption that it will be required only if the Drew School undertakes a full curriculum in undergraduate medical education including research and teaching in the basic biomedical sciences.

5.5.4 Instructional Facilities - Allied Health Professions

General Function: This element is intended to provide essential non-clinical teaching facilities for students in allied health professions programs conducted under the aegis of MLK-Drew. These programs will include the Medex and physician assistant programs and a variety of programs training community health workers, as well as future Allied Health Professions programs as they are developed and implemented. Faculty members teaching in such programs who need not be located in a clinical setting will also be based here.

Type of Space: This is non-clinical instructional space and will include classrooms, seminar rooms and small group study areas, some teaching laboratories, and faculty offices. The specific types of space may vary widely according to program needs and they are difficult to foresee in detail. Some faculty members may require research space but this is believed to be limited and can be defined only after programs are developed and faculty recruiting is begun.

Estimated Size: 30,000 net square-feet

Relationships: There are two principal physical relationships which should be considered when locating this program element on the site. First, physical proximity to the Learning Resources Center is regarded as important since the Center will play a vital role in the support of these educational programs. Considerable traffic, both in students and in teaching materials, should be anticipated between these two elements. Secondly, the Instructional Facilities for Allied Health Professions should be located with convenient access to MLK Hospital inasmuch as many of these students will also be involved in clinical training taking place in the hospital, its clinics and emergency facilities. This is not meant to imply physical connection with the hospital, but neither is a location several blocks away acceptable. We envision this facility as appropriate for a location within the Drew School's academic complex, but within a few moments walking time of the hospital.

Planning Assumptions and Unresolved Questions: We have assumed that, initially at least, programs in the allied health fields will of necessity be housed principally in MLK Hospital and will further be dependent upon the colleges in the Allied Health Consortium. Recognizing that learning space in the hospital is severely lacking, we have included limited classroom, seminar, and self-instructional areas in the Learning Resources Center (Phase I) which can be utilized to some extent by these programs. This program element has been designated as a high priority element and we have consequently assumed a Phase II schedule. However, if MLK Hospital's future expansion does not add the presently projected number of beds, it is possible that some badly needed additional teaching spaces could constitute part of the hospital's expansion. This would be a better solution since

it would place such teaching facilities close to where students are receiving clinical training. It might also have an impact on size and type of space needed in this program element. Detailed planning for this element should therefore be done in collaboration with planning for the hospital's expansion.

Our planning has also been based on the belief that programs in the Allied Health Professions can fill critical needs for trained manpower in the service area, contribute directly to improving the level of health in the community and assist indirectly in improving economic conditions by providing some area residents with marketable skills. These views are most evidently shared by Drew faculty and administration and such programs are seen as having an almost immediate and visible impact. Further development of such programs should therefore proceed as expeditiously as possible even though only interim housing can be provided for them, rather than delay their development until a permanent home is available.

We have obviously assumed an administrative organization of the Drew School which includes the development and conduct of such programs by a faculty of Allied Health Professions, even though no dean for such a faculty is now on board. A further matter which needs early definition involves the relationship between programs in allied health fields conducted by the Drew School and similar educational programs conducted by MLK Hospital. This will become critically important in the future and may result in competition for in-hospital teaching space as well as affect planning for both the Learning Resources Center and Hospital Occupations Training (HOT) Center. In order to avoid jurisdictional disputes, needless duplication of staff, equipment, and facilities, and added costs, planning for both programs and facilities should be undertaken jointly and relationships defined in the very near future, as recommended by the Task Group on Postgraduate Training. Our recommendation is that both the planning and implementation of all programs in allied health fields be the joint responsibility of both MLK Hospital and Drew School.

5.5.5 Child Care Center

General Function: The program for a 24-hour child care center within the MLK-Drew complex has been primarily developed by the department of Pediatrics and Aid to Needy Children Mothers Anonymous, a community group composed mainly of mothers on public support. A working relationship of about two years has brought forth the following child care program, to meet a variety of needs and goals:

1. To provide 24-hour child care for children of single parents who are hospitalized;
2. To provide care for children of hospital employees and parents in the various training programs;
3. To establish programs of child care, rehabilitation and restoration of normal family relationships for children who have received non-accidental injuries (i.e., "battered children") or for infants or children who fail to thrive;
4. To establish programs of child care for multihandicapped pre-school children;
5. To develop a training program for child care workers that is based both on the principles of child development and the cultural characteristics of the community;
6. To develop a total program that closely interacts with parents, community groups, other child care programs, so that the extended community is involved in continual dialogue and education regarding optimal child development.

Type of Space: A considerable variety of spaces will be required to meet the various aspects of these programs. These will include living and sleeping rooms, "sick bays" for children suffering from minor disorders not requiring hospitalization, offices for administrative and teaching staffs, conference rooms, classrooms both for children and for adult trainees, and service areas such as a kitchen, a laundry (unless the hospital laundry is used), storage rooms, and outdoor play space. The exigencies of funding dictate that the first components, at least, of the Child Care Center will necessarily be housed in "relocatable" buildings.

Estimated Size: The following estimates have emerged from the planning process:

<u>Priority</u>	<u>Area NSF</u>
1. Day Care Function for 100 Children	11,000
2. Child Abuse Program	5,000
Multihandicapped Child Program	5,000
3. Children of Hospitalized Parents (50 Children)	7,000
	<u>28,000 NSF</u>

We suggest that this estimate be increased to 30,000 NSF to provide a small allotment for additional teaching and administrative functions. (A program in learning disabilities will require a modicum of administrative space as it will operate within the schools.)

Relationships: The two principal relationships that must be maintained are to the community (including the schools) and to King Hospital, chiefly the pediatrics service. Negotiations are presently under way between Drew, the WLCAC, and the Economic Resources Corporation for the acquisition of about two acres just north of and adjacent to the County land set aside for the future development of Drew. This site would appear to meet the principal relationship needs of the Child Care Center. It is accessible to the community. It will be close to the school's administrative support functions, such as the Learning Resources Center. It is sufficiently close to King Hospital (2 blocks) for employee parents to drop off and pick up their children conveniently and for the children to be taken to visit their hospitalized parents. As this will be a temporary structure (see below), this choice of location should not interfere too greatly with long range plans for campus development.

Planning Assumptions and Unresolved Questions: The programmatic requirements for the Child Care Center have been spelled out in the funding applications for the individual programs, which represent much thoughtful and realistic planning by those who have been involved during the past two years. The principal unresolved issues are those regarding funding, both for capital construction and for operation. As noted above, negotiations are currently under way both for site acquisition and for an initial increment of building, which will, for funding reasons, be in a temporary structure. Further planning and programming must necessarily be deferred until the amount of funds available and the conditions of their use have been made clear.

5.5.6 Ambulatory Care Center

General Function: The function of this center is to provide a demonstration setting for the delivery of health care services to a defined population of 30,000 on an ambulatory patient basis. It will also provide an environment for research in the various methods of organizing and implementing the delivery system of health care services to ambulatory patients. No beds or inpatient services are envisioned; however, this ambulatory care center will depend on Martin Luther King, Jr., General Hospital for back-up services. Further, this center will function as a principal location for training residents, particularly in the primary care specialties of family practice, internal medicine, and pediatrics. Residents in community medicine will also be trained in the center. The extent to which other types of students will be trained in this facility is not known now.

Types of Space: The space required in this program element will consist principally of office and examination/treatment rooms, patient waiting areas, specialized clinic support space, storage areas for equipment and supplies, clinic administration and patient record areas, and a small clinic pharmacy. Outpatient surgery will require that a small operating room or suite be provided for ambulatory patients here. Limited diagnostic services such as radiology and clinical labs will be required in this facility for routine procedures.

Estimated Size: 40,000 net square feet

Relationships: On the basis of experience with hospital related ambulatory care programs, we urge the organizational and physical separation of the ambulatory care center from the hospital. If conservation of scarce physical and human resources were the main criterion, we would recommend maximum integration of the center and the hospital. We believe, however, that this would lead to an inordinate emphasis on the needs of hospitalized, acutely ill patients, to the detriment of the ambulatory care center programs. If economic considerations require an immediate physical attachment of the ambulatory care center to the hospital, the risks inherent in such a situation should be noted and procedures established to avoid the tendency toward acute care domination which has plagued existing ambulatory care centers.

Planning Assumptions and Unresolved Questions: There are essentially only two givens with respect to this program element, which have been derived principally from discussions with the Drew School Administration and the department of Community Medicine: (1) that it is a patient care center serving only ambulatory patients, and (2) that the defined population will be approximately 30,000 people. All else is either assumption or unresolved question. How the clinic is to be organized and what services are to be offered remain to be defined. For example, if only care services which can be classified as primary care are to be provided, this will generate a different organization and a different patient load than if both

primary and secondary care services are offered. Primary care visits tend to generate a significant load in the secondary care categories as diseases progress and more complex conditions are diagnosed through routine physical examination and screening. This secondary care load must be accommodated somewhere and it is questionable how much of it should be absorbed into the existing specialty clinics of MLK Hospital without diluting the latter's principal mission as an acute inpatient care facility. In addition, if continuing, comprehensive care delivery is an objective of the ambulatory care center, then obviously services should extend beyond the primary care specialties. For these reasons, we have made the assumption that both levels of care will be provided here for ambulatory patients and that while this may duplicate some of MLK's clinic services, each will be serving an essentially different patient population.

The number of patient visits to be accommodated here is subject to other factors as well as what level of services are offered. A fair assumption is that any 30,000 people in this community will tend to need more health care than a similar sized group in a non-ghetto area and may therefore visit the center more often. Payment mechanisms also affect utilization rates with prepaid systems tending, on the whole, to generate more visits than the fee-for-service payment arrangement. Some sort of prepaid mechanism has been mentioned frequently as desired and is in line with the need to define the patient population served by this facility. Estimated numbers of patient visits per person per year can vary from 2.5 to 4. Based on the above speculation we have assumed the higher ratio as more likely. This would result in approximately 120,000 patient visits per year. In addition, there may be a referral load of as much as 10% or 12,000 visits by persons who are referred into the clinic by their private physicians, or MLK Hospital. Thus it would seem reasonable that this facility should be of sufficient size to accommodate 150,000 patient visits per year.

How this estimated load will break down between primary and secondary care services can only be guessed at now. Only after the more specific characteristics of the defined patient population are known can this be determined with a greater degree of accuracy. For present planning purposes space estimates assume a 50% primary-50% secondary caseload.

The space required for the center will also depend to some extent on the hours that it is open for service. We have tested two alternative sets of assumptions: (1) that the center will be open 16 hours a day, 7 days a week, and (2) that the center will be open 8 hours a day, 5-1/2 days a week. In both cases we have a 50 week per year operation allowing for holidays. We have also assumed an estimated 75% efficiency (due to scheduling difficulties and the unknown nature of the caseload at least initially). We have assumed an estimated 1 to 1.5 visits per exam room per hour, which will amply accommodate teaching functions. This assumes that student training will take place, which increases patient encounter time. Our best recent experience shows a fairly consistent 66 minutes per visit when students are present.

Since the mix of caseload is unknown, and for that matter will probably always fluctuate, we have assumed a modular arrangement of clinic spaces including offices, exam rooms, waiting areas and support spaces, which is largely undifferentiated between primary and secondary care functions. These could be arranged on a repetitive basis with only the support spaces adapting to the specific clinical activities carried on in each module. This would accommodate the ebb and flow of varying caseload and would provide sufficient flexibility for changing functions.

The space estimate of 40,000 NSF for this facility is based on the second set of assumptions mentioned above, i.e., an 8 hour per day, 5-1/2 days per week operation. This results in a need for a total of 14 clinic modules each containing six examination rooms. If the clinics are operated on a 16-hour per day, 7 days per week basis, this could have two results. It could reduce the space required particularly in exam room clinic modules to handle the same patient load on an extended schedule basis. It is doubtful that the support space could be reduced to any significant extent, but waiting areas could perhaps be smaller. We do not believe it is valid to assume that the space could be cut in half by doubling the clinic hours, because the patient load during the second 8-hour shift cannot be assumed to be the same as during the first 8-hour shift, even by utilizing a sophisticated scheduling system. The other result of a 16-hour per day, 7 days per week operation could be a sizably increased patient load if the space is kept at 40,000 NSF. In other words, many more than 150,000 patient visits per year could be handled on a 16-hour basis in the same space, though probably not twice as many. For present planning purposes we have adopted the larger space estimate of 40,000 NSF as being more conservative, with the knowledge that it can be reduced rather than increased with careful planning and greater definition of services.

Given the characteristics of the patient population, with many families having young children, and recognizing the desirability of not forcing employed persons to take time off from work, we recommend that the ambulatory care center operate on more than an 8-hour day, 5-1/2 days per week basis. Alternatives, such as operating only the primary care clinics on a 16-hour, 7-day basis, or providing a 24-hour drop-in clinic should also be explored.

Other unresolved questions abound with respect to this ambulatory care center. Staffing patterns, for example, must await more precise definition of services to be offered and caseload characteristics. The administrative as well as the physical and operational interface with the MLK Hospital requires much greater definition. In addition, more information must be developed on the educational programs to be conducted here, i.e., how many students, at what levels, engaged in what activities, etc. Now, or even if, this facility will be expected to fit in with an overall network system of ambulatory care centers serving the entire MLK-Drew service area needs to be explored in depth before relationships of this facility to other resources can be determined. This will undoubtedly be a subject for early

consideration by the task group on the Health Care Delivery System discussed in Section 3 above. The various ways in which the services offered here might be manipulated or restructured for purposes of research in health care delivery may substantially affect the physical design of this center and should be carefully considered during future planning and programming. The resolution of all of these questions and assumptions will have significant impact upon both the capital and operating costs associated with this program element.

Among the criteria that this facility should meet, whatever its final configuration or size, are the comfort of patients and the effective utilization of the staff. The first can be achieved at least partially through providing a warm, welcoming atmosphere instead of the institutional austerity so frequently encountered in clinic settings. In addition to a well trained staff, sympathetic to patient problems and anxieties, provision should be made for comfortable, dispersed waiting areas for patients rather than hallways lined with chairs or large impersonal waiting rooms. Professionally supervised play areas for children should also be planned as a part of this facility. In order to make the most effective use of the staff, at least a "block" appointment schedule system should be instituted. This would avoid the extremes of attempting to staff for peak levels to avoid queuing of patients or having staff under-used if patient load is light. It will likely take some time to initiate the most appropriate appointment system and to educate patients on the importance of keeping appointments. However, in the long run it is worthwhile both from the standpoint of personalized health care and greater staff efficiency.

Recognizing the variety of questions that remain to be resolved with respect to this ambulatory care center, there are certain recommendations that we would make as consultants to provide guidelines within which planning can proceed. First, we urge both the administrative and the physical separation of the ambulatory care center and King Hospital. The functions of the two are essentially different, with the emphasis of the hospital on acute inpatient care and the ambulatory care center concentrating on preventive, continuing care. The principal interests of those staffing the ambulatory care center should be in health maintenance rather than disease episodes. It is likely that if separation of these two units is not maintained and if staff interests are not respected, the goals of the ambulatory care center will not be achieved. Rather, it may well become a "step-child" of the more pressing needs of the acute care function.

Secondly, we recommend that this center be developed as the first of

a series or network of ambulatory care facilities extending out into the service area. It should serve as a model or experimental unit to investigate care delivery methods, but lessons learned here should be extended to a network of other centers to be truly effective. Ways of extending this knowledge should be explored whether or not the Drew School takes on operational responsibility for the entire network.

5.5.7 Continuing Education Center

General Function: This facility (which is not necessarily a free-standing building) will house those persons responsible for organizing meetings, symposia, seminars, and other kinds of programs conducted for health practitioners so that they may continue to refine the skills and judgment necessary to apply their knowledge to the problems of health and disease, particularly within the service area. Such programs should be conducted within the Continuing Education Center itself and at a number of other locations in the community. The Center's facilities can also serve programs in consumer and public health education.

Type of Space: Office and conference room space for the administrative staff of the Center will be needed as well as workroom and storage areas. Classrooms, meeting and demonstration areas should be included, to supplement those available in the Learning Resources Center and to provide a setting for programs not requiring a clinical environment. All such spaces should be fully suitable and equipped for audiovisual and television presentations and can be expected to draw heavily on the Learning Resources Center for such support. Some limited kitchen, dining, and food service areas should also be included. Consideration should also be given to including a small number of hotel-type sleeping rooms for persons attending extended continuing education programs. These may be needed if such space is not available in the interns-residents dormitory facility and if motels are not available in the immediate vicinity of the MLK-Drew campus.

Estimated Size: 15,000 net square feet

Relationships: Because of the variety of programs this Center will support, a location near the Learning Resources Center and the Auditorium is seen as highly desirable. MLK Hospital should be within easy walking distance as well. Good public access will be essential and the Center should be conveniently located near parking areas and public transportation. External or off-site relationships, while more administrative or functional than physical, will be extensive and critical with respect to the activities conducted by the Continuing Education Center. We envision the Center serving a "command post" and coordinating role in programs of continuing education presented in cooperation with local professional groups, organizations, and other hospitals and occurring in many other locations throughout the service area.

Planning Assumptions and Unresolved Questions: We have assumed that many of the activities and programs in continuing education will not take place at night or on weekends when there would be few conflicting demands for classrooms and auditorium space. In fact, we have assumed that as programs develop there will be increasing demand among them for such space and that scheduling will become difficult unless more space of this type is provided. This Center has a Phase V designation on the assumption that continuing education pro-

grams will have developed to the point where they will have outgrown space available elsewhere in the MLK-Drew complex by that time. The commitment by the Drew School to the development of such programs is substantial and they occupy a high priority among the school's objectives. Ideally, this facility would be among the first constructed by the school. However, due to severe problems of obtaining construction funds we have been forced to assume a lower priority for this Center but urge that such programs be started long before this facility is completed, utilizing space in the Learning Resources Center, MLK Hospital, Allied Health Professions Instructional Facilities, and community resources such as schools and other hospitals in the service area.

5.5.8 Auditorium

General Function: This will be a multipurpose facility serving the needs of virtually all programs of the Drew School for large-group auditorium style seating. This facility will be in addition to the auditorium connected to MLK Hospital. It will serve academic programs in postgraduate medical education and the allied health professions as well as programs in continuing education, consumer and community health education. In addition, it can be expected to serve as a community auditorium for functions not connected with health education or formal training programs.

Type of Space: The auditorium should have a seating capacity of 400 persons and should be able to accommodate a number of different situations, from lectures and demonstrations to community activities of a cultural nature. Effective capability for the use of all audiovisual techniques including television projection and monitors will be essential. Demonstration preparation areas will also be needed. The use of this facility as a community cultural center will likely involve such activities as theatrical and musical presentations which will add to space requirements to accommodate a stage, wings, and suitable storage areas.

Estimated Size: 7000 net square feet

Relationships: The principal requirement of this facility is that it be located conveniently for users. Therefore, it should not be too remote from such program elements as the Learning Resources Center and the Continuing Education Center. Like the latter, good public access will be important as will convenient parking areas. This facility will be a part of the Drew School's interface with the community and should be recognizable as such.

Planning Assumptions and Unresolved Questions: We have assigned a Phase V designation to this program element, and suggest that it be planned in conjunction with the Continuing Education Center.

5.5.9 Other Research Laboratories (Principally Basic Sciences)

General Function: This program element will provide additional space for the Drew School faculty members, specifically those involved in teaching the basic medical sciences (biochemistry, anatomy, physiology, etc.) to undergraduate medical students. This element will also house additional clinical sciences faculty required to conduct the school's expanded programs in undergraduate medical education.

Type of Space: The largest part of the space in this program element will be devoted to faculty research space, principally "wet" laboratories. Such spaces will require access to a wide range of utilities and services including hot and cold water, distilled water, acid waste, vacuum, air, and gas. Related areas supporting the research laboratories will include darkrooms, warm rooms, cold rooms, special equipment areas such as electron microscopy suites, radioisotope labs, tissue culture labs, media preparation, and, of course, storage areas. Most of these support areas will also have high utility and service needs. In addition, offices will be needed for faculty members, postdoctoral fellows, and others involved in research here. Linkages (at least terminals) to computer services will be needed as well. Departmental administrative space, including department heads' offices, secretarial offices, conference, and workrooms will be required for these basic science departments. A fabrication and maintenance laboratory should also be a part of this program element to provide competent services to faculty in scientific instrument design, construction, testing and maintenance. This space will consist of shops for metal working, wood working, electronics, optical and other specialized laboratories for sophisticated procedures (e.g., nuclear magnetic resonance) and storage areas.

Estimated Size: 55,000 net square feet

Relationships: The offices and laboratories housing basic sciences faculty should be located close to the instructional facilities for the undergraduate medical curriculum, both for the sake of faculty convenience and in order to promote close, informal relationships between faculty and students. Ideally, a very close physical relationship is desired between this program element and the Clinical Sciences Facility planned by the County adjacent to MLK Hospital. Basic sciences faculty space should also be located conveniently with regard to the Learning Resources Center whose services and collections will be heavily used by them.

Program Assumptions and Unresolved Questions: This program element is based on numerous assumptions. First among these is the assumption that the Drew School may ultimately decide to undertake a full undergraduate medical school curriculum, including teaching the basic sciences to students in such a program. We have recommended that this not be undertaken; but if it is, it should be the last of the Drew School's major program endeavors. For this reason, we have assigned this element a Phase VI priority.

Heavy dependence of this element on the Clinical Sciences Facility to be constructed by the County is also assumed. For example, we have not planned any additional experimental animal facilities beyond the 20,000 or so square feet we understand will be a part of the County Clinical Sciences Facility. Our assumption is that these animal facilities, if built, will be adequate to support the research activities of both clinical and basic sciences faculty as well as teaching needs. We have, however, assumed that this County facility will not be sufficient to house the full complement of clinical sciences faculty who will be needed if the undergraduate medical curriculum is added. Our space estimates for this program element (Other Research Laboratories) are based, therefore, on an assumed addition of approximately 50 basic sciences faculty and another 25-30 clinical sciences faculty needed to accomplish the undergraduate program.

Laboratory space in this element should be designed to be as modular and flexible as conceivably possible and should be assigned on an "as needed" basis, allowing for reassignment as required by changing research interests of faculty, rather than assigned on the basis of departmental "territory." Maximum sharing and centralization of supporting facilities for these research laboratories will be essential to keep the space allocations within reason and to avoid expensive duplication of space and equipment. A further assumption is that only those faculty who have "wet" laboratory research needs will be accommodated in this program element and that faculty, particularly clinical faculty, whose interests do not include this kind of research laboratory activities, will have offices in the hospital only.

The construction and final space assignments in the Clinical Sciences Facility will have a very significant impact on the programming and planning of this element. We understand that sufficient space to accommodate approximately 100 Drew School clinical faculty is planned in the County building. We also understand that space presently provided in the hospital for such services as radiology, pathology, and clinical labs is severely short and that these functions may need to expand into the Clinical Sciences building. If this happens, the Drew School may not realize adequate space in the County building for its clinical faculty, and projected animal facilities may also be trimmed. In this event, this Drew School program element will have to be increased in size to make up the clinical faculty office and research space and animal facilities not provided in the County's Clinical Sciences Facility.

5.5.10 Instructional Facilities (Undergraduate Medical Curriculum)

General Function: This program element is intended to house the instructional space required to teach students in an undergraduate medical school curriculum in the basic sciences if the Drew School ultimately sponsors such a program.

Type of Space: Multipurpose teaching laboratories, gross anatomy dissection laboratories, their required supporting spaces, additional classrooms and seminar spaces, and possibly student carrels will comprise this element. A small component of student activities space such as a lounge, snack area, and offices for student organizations may also be required. Teaching laboratories and their support space (stockrooms, media preparation, glass-washing, teaching materials preparation, etc.) will need extensive utility services and the use of cadavers for teaching will require specialized preparation and storage spaces. All teaching and learning spaces should have full provision for use of multimedia instructional aids.

Estimated Size: 30,000 net square feet

Assumed space allocations in this element are as follows:

<u>Component</u>	<u>Area NSF</u>
Multipurpose labs and interlabs for 100 students	8,000
Teaching laboratory support	4,000
Gross anatomy labs	3,500
Gross anatomy support, prep, and storage	2,500
Student carrels for 100 students	3,500
Seminar rooms	1,500
Classrooms	4,000
Student activities areas	3,000
	<u>30,000</u>

Relationships: The space in this element will be principally devoted to teaching the basic sciences (rather than clinical sciences) to undergraduate medical students. Consequently, it should not be located remotely from the offices and research laboratories of the faculty teaching here. Further, since the use of animals may be expected in these teaching labs, this program element should be located close enough to the County's Clinical Sciences Facility so that animals may be easily transported between these two. Physical proximity to the Learning Resources Center is also desirable. Gross anatomy facilities should be carefully placed away from public or visitor access and close to a receiving area and cadaver preparation and storage areas to minimize movement of cadavers.

Planning Assumptions and Unresolved Questions: For planning purposes we

have assumed a medical school entering class size of 100 students as representing a sufficient magnitude to be economically efficient. Space and faculty estimates are therefore based on what will be needed to teach at this level. It should be stated that these estimates are to be regarded as "ball park" guesses and that many factors will influence their accuracy. Specifically, the length and emphasis of the curriculum, teaching methods employed, in addition to the defined objectives of such a program, will all have a significant impact on what is needed. It would be premature, to say the least, to attempt definitions of such factors at this time.

Space estimates in this program element assume 100 student stations in a multidiscipline laboratory setting. If the basic sciences portion of the curriculum occupies the bulk of the first two years of the program, this will mean that these laboratory stations must be shared among 200 students. Careful scheduling should allow this with little difficulty, particularly since recent trends in medical education appear to de-emphasize time spent in laboratory exercises. Space estimates for the gross anatomy dissection laboratories provide for one full class at a time and do not necessitate scheduling this activity. Carrel space is also based on sharing rather than on an assigned "home base" concept. Two large classrooms, each accommodating 120 students, and six smaller conference-seminar rooms are included in the space estimated here. No additional animal space is included in this element and dependence on the County facility is assumed.

This facility has been assigned a Phase VI priority, based again on our recommendation with respect to basic sciences teaching for undergraduate medical students. As discussed, under each appropriate element description, implementing such a program will also necessitate expanding the Learning Resources Center, the Drew School Administration Unit and the Services Unit. The impact of this program upon clinical facilities and patient care services has not been investigated.

5.6 PERSONNEL ESTIMATES

The following table, "Estimate of Personnel Build-Up," represents a possible program of personnel acquisition from the present time until a "steady state" of full development is reached. Based on present program planning, we have somewhat arbitrarily assumed that reaching a "steady state" will take about ten years. The principal criterion in arriving at these estimates has been to assure that sufficient staff of the appropriate categories will be on hand to staff the programs housed in each component of the development program as it is completed. In the case of faculty--particularly basic sciences faculty if undergraduate medical students are to be taught--this calls for recruiting faculty who will be engaged in planning and preparation during several years preceding the opening of any permanent facilities. The presence of these faculty will also, of course, generate a need for such supporting staff as secretaries and laboratory technicians.

In the case of undergraduate medical students, we have assumed that the Drew School will offer clinical clerkships at King Hospital to students who have done their preclinical work at other schools (e.g., USC, UCLA). Since facilities and faculty already exist, the constraints are more organizational than physical. We have chosen to show the beginning of a program of clinical undergraduate medical education in Year 3 of the "ten-year" plan.

In our view, Drew should limit its participation in undergraduate medical education to clinically oriented and hospital based programs of the clinical years. If, however, Drew decides to offer a basic sciences curriculum also, it should begin, on a small scale, in temporary quarters, about two years before the Phase VI basic sciences teaching building could be ready for occupancy. As noted above, this requires the recruitment of faculty even earlier.

The column headed "Steady State" is an estimate of the numbers of faculty, staff, and students who can be accommodated on the Drew campus when the proposed development program has been completed.

ESTIMATE OF PERSONNEL BUILD-UP, DREW SCHOOL.

YEAR*	0	1	2	3	4	5	6	7	8	9	10	"Steady State"
Development Phase Completion					I, II	III	IV	V			VI	
Clinician Faculty	70	110	120	130	140	150	160	170	175	175	175	175
Allied Health Sciences Faculty	0	10	20	25	35	40	40	40	45	45	50	50
Basic Science Faculty	0	0	0	0	0	0	10	20	30	40	50	50
Administrators	12	15	15	15	20	20	25	25	30	35	40	40
Other Professionals	15	20	25	30	35	40	40	45	45	50	50	50
Clerical, Technical, Etc.	80	100	120	140	160	180	200	220	240	260	280	280
Allied Health Sciences Students	100	125	150	175	200	250	300	350	400	400	400	400
Undergraduate Medical Students - Clinical	0	0	0	30	50	70	100	125	150	175	200	200
Undergraduate Medical Students - Basic Sciences	0	0	0	0	0	0	0	0	25	75	150	200

* For purposes of demonstrating the incremental build-up of personnel in order to meet program requirements, we have assumed that the steady state will be reached in ten years.

5.7 CONSTRUCTION AND PROJECT COST ESTIMATES

The preliminary capital cost estimates presented here cover construction and project costs for those physical facilities discussed in the foregoing sections. All estimates are given in terms of January 1973 costs and have not been escalated to mid-construction period, as is customary, to allow for rising costs due to inflation. We have not escalated these capital cost projections because it is not possible at this time to foresee the specific construction schedule for all of these facilities with any reasonable degree of accuracy. We feel that such construction period guesses would be misleading until certain major decisions have been made and priorities agreed upon by the Drew School.

Costs have been estimated on the basis of standard construction. These costs can be somewhat reduced if any of the program elements can be housed in prefabricated, modular structures. It must, however, be pointed out that such structures are relatively extravagant in the use of land.

For those readers who want to assess the impact of inflation on these cost estimates, our best past experience shows an escalation factor in the neighborhood of 10% per year to be not unrealistic. For example, if a facility costs \$50.00 per gross square foot to construct in mid-1973, this means the same facility would cost \$55.00 per gross square foot in mid-1974, \$60.50 per gross square foot in mid-1975, \$66.55 in mid-1976, and so forth.

These estimates are given for each phase of development, based on our assessment of priority for each program element as presented in Section 5.4 above. The reader is also referred to Section 5.1 for definitions of terms used here such as "net square feet," etc. It might be well, however, to re-emphasize the distinction between "construction cost" and "project cost." Construction costs include only the building structure; mechanical, electrical and other utility systems; fixed equipment and finishing. Project cost adds to the above certain allowances to cover limited site preparation work (including utilities connections within the building site only); construction bonds; a contingency allowance; architects, engineers, and consultants fees; insurance and supervision costs; and the cost of movable and scientific equipment. The project cost estimates given in this report have been arrived at by applying a uniform "Project Cost Factor" of 1.35 to construction costs (i.e., construction cost $\times$ 1.35 = project cost). The cost of acquiring land is not included in our projections of construction or project cost and must be considered an additional expense. We have made no estimates of the cost to the Drew School of buying additional land, nor of such owner costs as demolition.

It will be evident to the reader that we have used different net-to-gross factors for different types of space. This is because certain kinds of space tend to have a higher net or usable ratio than others regardless

of architectural design or construction methods. For example, space that is principally office and conference space has lower utility requirements than laboratory space, resulting in less gross square footage devoted to mechanical space, and thus tends to be more efficient in its net-to-gross ratio. Accordingly, we have used net-to-gross factors of 1.4 for the auditorium and service unit; 1.6 for office, conference, classroom, and administrative space and the Learning Resources Center; and 1.8 for laboratory and similar space with high utility and circulation requirements. (The higher the net-to-gross factor, the lower the efficiency of the space, yielding less space that is actually usable or assignable.)

We have also used varying construction cost estimates per gross square foot depending upon the type of space involved. Office and administrative space is generally less expensive to build so we have estimated its construction cost at \$48.00 per gross square foot. On the other hand, laboratory space is more sophisticated with high utility and mechanical costs, so its construction cost is estimated at \$68.00 per gross square foot. Certain facilities, such as the Ambulatory Care Center and the Allied Health Sciences facilities fall about mid-point on this scale, so we have used a gross square foot construction cost of \$55.00 for these elements.

All of these construction cost projections are based on the best recent information we have found available for construction costs in the Los Angeles area for 1973. It cannot be overemphasized that these cost projections are no more than modestly informed guesses based on myriad assumptions. As construction programs per phase are established and real target dates identified, the assumed program elements should be modified and planned in detail. More definitive cost data, as it becomes available and applicable to specified programs, should be used to modify these cost projections.

As presently assumed, this program would require ten or more years of continuous construction, an expensive and disruptive undertaking. The planning problem posed by this, while typical, is seldom considered on its own merits. It revolves around the alternatives of financing a large number of small pieces over a long time, or a small number of larger pieces over a shorter time. In other words, how shall the capital investment be made: in a large amount at the outset to realize the benefits of reduced escalation (inflation), or in a small amount at the outset paid for by the premium of inflated costs, continuing disruption, and delayed occupancy? We strongly recommend that the advantages and disadvantages of these alternatives receive considerable analysis by the Drew School.

PHASE	PROGRAM ELEMENT	NSF	NET-TO-GROSS FACTOR	GSP	S/GSP (1973 \$)	CONSTRUCTION COST	PROJECT FACTOR	PROJECT COST
I	LRC	40,000	1.6	64,000	548.00	53,072,000	1.35	54,147,000
	Admin. Unit	20,000	1.6	32,000	48.00	1,536,000	1.35	2,076,000
	Service Unit	10,000	1.4	14,000	48.00	672,000	1.35	907,000
	Subtotal:	70,000		110,000		55,280,000		57,128,000
II	Instr. Fac. (ARS)	30,000	1.6	48,000	555.00	52,640,000	1.35	53,564,000
	Subtotal:	30,000		48,000		52,640,000		53,564,000
III	Child Care Ctr.	30,000	1.8	54,000	548.00	52,592,000	1.35	53,499,000
	Subtotal:	30,000		54,000		52,592,000		53,499,000
IV	Anth. Care Ctr.	40,000	1.8	72,000	555.00	53,960,000	1.35	55,346,000
	Subtotal:	40,000		72,000		53,960,000		55,346,000
V	Cont. Ed. Ctr.	15,000	1.6	24,000	548.00	51,152,000	1.35	51,555,000
	Auditorium	7,000	1.4	9,800	48.00	470,000	1.35	635,000
	Subtotal:	22,000		33,800		51,622,000		52,190,000
VI	Res. Labs (S.S.)	55,000	1.8	99,000	548.00	56,732,000	1.35	59,088,000
	Instr. Fac. (S.S.)	30,000	1.8	54,000	48.00	53,672,000	1.35	4,957,000
	Service Unit	5,000	1.6	7,000	48.00	336,000	1.35	454,000
	LRC (Add'n)	10,000	1.6	16,000	48.00	768,000	1.35	1,037,000
	Admin. Unit (Add'n)	5,000	1.6	8,000	48.00	384,000	1.35	518,000
	Subtotal:	105,000		186,000		61,892,000		61,892,000
V TOTAL - ALL PHASES		297,000 NSF		501,800 GSP		577,900,000		537,781,000

PROJECTION OF CAPITAL COST ESTIMATES

3.2 SOURCES OF CAPITAL FUNDS

The program of phased development and the estimates of capital cost made in the preceding sections have been based on the Drew School's expressed needs if programs that are now being considered are to become operational. The availability of capital funds has not been an element in arriving at these estimates. Clearly, however, the school's ability to turn these projections into fact will depend upon finding sources of sufficient funds. This is the problem which is discussed in this section.

It is probably not over-dramatic to describe the current situation in regard to the financial support of medical education as traumatic. Throughout the country, both well-established schools and schools in development have been hard hit by the drastic reduction of federal participation in the construction of new facilities as well as in the restriction of programs supporting research and training. The bleak fact is that for the foreseeable future neither Drew nor any other medical school can realistically expect a single dollar of federal money in the form of the joint construction grants that have been a principal source of construction funds for schools of the health professions.

Fortunately, Drew is not entirely without other potential sources of support for its building program. These sources are (1) Los Angeles County, (2) the State of California, and (3) the private sector.

As has been noted elsewhere in this report, Los Angeles County represents the major present source of Drew's operating funds under a contract in which the County currently pays Drew approximately a million and a half dollars a year for the medical care rendered in King Hospital by the faculty. Furthermore, the County has undertaken to build a Clinical Sciences Facility to be occupied by Drew faculty engaged in clinical and biomedical research. The extent to which the County will participate in other capital construction for the school will probably depend upon the degree to which such construction can be shown to contribute to the health care of residents of the surrounding community. The decisions to be made are partly fiscal and partly political, involving such factors as the setting of priorities in allocating funds among the various County hospitals. Yet there would appear to be a prima facie case for County participation in the construction of the Ambulatory Care Center. The Learning Resources Center represents another opportunity for funding participation by the County insofar as the LRC will be serving (and perhaps physically accommodating) such hospital-oriented programs as the Hospital Occupations Training Center. It goes without saying that Drew stands to benefit from exploring all available opportunities for County support.

As noted elsewhere in this report, the State of California, acting through a Subcommittee on Medical Education of the Senate's Committee on Health, Education, and Welfare, has expressed an interest in the development

of undergraduate medical education at Drew.

Restricting undergraduate education to clinical education would have clear financial advantages to Drew. Above all, the school would be spared the extraordinary expense of building basic sciences faculty and teaching facilities as well as supporting a basic sciences faculty. The physical facilities to teach basic sciences on the Drew campus comprise almost the entirety of Phase VI as follows:

	<u>1973 Estimated Project Cost</u>
Faculty Research Laboratories	\$ 9,088,000
Instructional Facilities	4,957,000
Service Unit	454,000
Addition to the LRC	1,037,000
Additional Administrative Space	518,000
	\$16,054,000

This amounts, even in terms of uninflated dollars, to about 43 percent of the entire building program. Even leaving aside the political and administrative problems of bringing Drew under the aegis of the State system of higher education, the clear message of the relative costs involved is that Drew should determine to stop short of offering the basic sciences curriculum on its campus.

If the legislature should continue to express an interest in supporting a program comprising only the clinical phase of undergraduate medical education, then Drew might indeed find itself in a position to benefit from State funding without raising some of the thorny problems (e.g., "competition" with other U.C. medical campuses) which would follow its undertaking, under State auspices, a complete program of undergraduate education.

Drew's third source of funds lies in the private sector. Traditional medical school fund-raising is directed heavily toward alumni and toward affluent members of any community that identifies itself with the welfare of the school. The first traditional source of private funds is not available to Drew as a developing school. We have been informed that the second source, which would call for a fund-raising campaign in the national black community, is not regarded as a promising prospect in view of previous experiences by other institutions. Nevertheless, we do not believe that this avenue should be rejected out of hand.

The potentially strongest stratagem for Drew to adopt would surely be to enlist the active assistance and support of its Board of Visitors in developing an approach to the private sector that could include but not be limited to the national minority community. Such an undertaking could be appropriately subsumed under the first two elements of the

Guidelines defining the functions of the Board of Visitors.

These read:

1. The purpose of the Board of Visitors is to provide counsel and assistance to the Board of Directors and Deans in pursuing the Drew School's mission as a regional and national resource.
2. In the public interest, the Board of Visitors will review the programs and progress of Drew School, assess the response to national health needs and issues in the light of the institution's capacity and commitments, and provide guidance in achieving institutional aspirations.

The Board of Visitors represents one of Drew's greatest resources, a reservoir of demonstrated talent and experience in public life, the professions, institutional administration, and the world of finance. As the school proceeds toward making its institutional aspirations real in terms of operational programs and buildings, the Board of Visitors may well provide the best means to achieve success.

6: The Planning Process

6. HISTORY AND ASSESSMENT OF THE STUDY PROCESS

6.1 INTRODUCTION

When the Bureau of Health Manpower Education (BHME) agreed to fund a major portion of the Drew Master Plan Study, one of its stipulations was that a process history be prepared so that the lessons from the Drew experience could be available to other medical institutions. Such a history is also useful to validate the study results by describing the involvement of Drew and community people in the process.

The process history is presented in three parts: a description of Phase 1 of the study (May 1971 to March 1972), a description of Phase 2 (March 1972 to April 1973), and an assessment of where the process worked and where it fell short of expectations.

It must be recognized that the history of the Master Plan Study was shaped by, and cannot be considered separately from, the history of development of the Drew School and the King Hospital. Where it succeeded, it owed much to the participation of the faculty and staff of the King-Drew complex as well as to local residents who took part.

6.2 PHASE 1 HISTORY, MAY 1971 TO MARCH 1972

A large part of the early work during Phase 1 was directed toward establishing lines of communication between the consultants and the school and between the consultants and the community. For reasons we will describe below, the first of these efforts was notably more productive than the second. (It might also be noted that the problem of improving communications between the school and the community in program development did not become a substantial part of the Master Plan process until Phase 2.)

In building lines for both communication and interaction between the school and the consultants, the principal formal mode was a series of conferences, of which twelve were held during the course of Phase 1 of the project. Both the number of participants in these conferences and the scope of discussion varied widely, from a meeting including only one MPS team member, the dean, and an associate dean of Drew, to all-day sessions involving all department heads, other faculty and staff members, and a majority of the MPS team.

The consultant-Drew meetings were designed not only as opportunities for the MPS team to report back to Drew and to encourage an exchange of views but were also conceived as opportunities for the participants to interact in a useful manner that, it was hoped, would elicit new insights and new solutions during the course of the meetings themselves. The

quality of the conferences varied markedly, with the most successful provoking candid discussions of substantive issues and leading to clearer understanding of the problems under examination. (In addition to these general conferences, MPS team members often met with the dean or others at Drew in regard to specific problems.)

A large part of the MPS team effort was devoted to interviews with the Drew faculty as well as with the administrators of the King Hospital. The purpose of these interviews was to elicit information regarding the individual faculty member's reasons for coming to Drew, his (or her) view of the institution and plans for program development, observations as to points of difficulty (or success) in attempting to plan for coping with the needs of the community, and any perceived internal conflicts within the MLK-Drew complex.

In summary, with regard to Drew School itself, the MPS team's activities were directed largely toward bringing into the open attitudes and opinions of the faculty, both individually and collectively, and obtaining information as to activities already undertaken or planned for the future.

The most ambitious of the MPS team activities directed toward the community were four meetings held with representatives of various neighborhoods in the study area. Organized by the UW, the meetings were attended by UW and ADL team members. The objectives of holding this series of "neighborhood panel" meetings were several. Familiarizing residents with the goals of the school, gaining some idea of the attitudes of residents toward the school, and identifying individuals who could speak for community interests and work jointly with the school in planning programs were among these. It was also hoped that some information on health care needs and community expectations of the Drew School could be gained from these gatherings.

The first neighborhood panel met on an evening in August 1971 with 27 residents of the Jordan Downs housing project in attendance. The second meeting, intended for residents of the Florence-Firestone community, attracted only three persons besides the MPS team members; the reason was thought to be a competing rally in East Los Angeles which, like Florence-Firestone, is populated by Mexican-Americans. The third meeting included about a dozen representatives of two community organizations (the Council of Community Clubs and Community Services of Los Angeles County) and Rancho Los Amigos Hospital. The meeting was reported afterward to have been largely devoted to orientation because of "the fact that none of the participants were familiar with the Drew School." The fourth (which turned out to be the final panel) met at the UW office, with 16 neighborhood people in attendance, on September 23. Like the previous meeting, it was devoted largely to acquainting the participants with the basic facts about Drew.

The third principal activity of the MPS team during Phase I was the largely technical one of collecting data that would help define the needs

of the community. This effort included indicators of the status of community health, the utilization of health services, general population characteristics, and the availability of health facilities and manpower. This work was carried out in close cooperation with the department of Community Medicine.

The preparation of the Phase 1 report represented the main milestone along the way to the accomplishment of the study's overall goals. As was noted in that document, "It is evident from the main body of this report that at the end of Phase 1 of the study the problem of community participation remains to be resolved." Solving this problem became one of the main thrusts of Phase 2.

6.3 PHASE 1 EVALUATION

In assessing the success of the Phase 1 process, two comments about the neighborhood panels are in order. An atmosphere of adversary confrontation was established early in the process with community representatives challenging the credibility both of the consultant group and of the entire meeting process. Among the substantive issues that emerged was the community's view of Drew as a provider of jobs and other economic services rather than primarily of educational and health care services. The second point has to do with the decision made jointly by the MPS team and Drew that Drew would not be represented at the meetings. It was generally agreed that previous meetings between the faculty and community residents had generated such stress and tension that open discussion might be inhibited by a Drew presence at the neighborhood panels. In retrospect this decision appears to have been mistaken, for it soon became apparent that the community people were puzzled and even offended by being asked to discuss their expectations in regard to health care with consultants--in other words, with middlemen rather than with the principals.

The idea of the neighborhood panel was consequently abandoned, largely out of disappointment over the lack of success in drawing the community people into active and productive discussion of such issues as their perception of the community's health needs. When, as in the initial meeting, there had been active discussion, it had been conducted in such a tone of opposition, misunderstanding, and hostility that further efforts at the time seemed counter-productive.

This decision now appears to have been premature. Study of the notes and tapes recorded during these meetings revealed much useful information about community attitudes toward the planning of the Drew School as well as some information about the health needs perceived by the community people. (A detailed analysis of this information was included in the Phase 1 report.)

On the positive side, much useful work was accomplished, particularly

in the course of the interviews with faculty members. From these came the first inventory of programs already in operation or proposed by the various departments. This in turn led to a reaffirmation of the commitment both by the school and by the consultants to develop during Phase 2 a means for creating institutional (rather than departmental) programs with the active participation of people from the community.

A final word is in order with regard to the Phase 1 process. The study took on a considerably greater degree of specificity when, relatively late in the process, an inventory was made of the programs already developed or planned by the departments. In retrospect, it now seems clear that this phase might have been more successful if the traditional planning process had been consciously reversed, and, instead of moving from universal statements to particular programs, the line of development had been from particular programs to universal statements.

Such a process might be generally described as first concentrating on a complete inventory of what is being done; moving from that to a summary of what is planned; comparing these to formulate complementary statements of problems and opportunities; abstracting from these statements the sense of mission and objectives they imply; ranking the resulting statements of problems and opportunities according to the real priorities allowed by available or expected resources; and, finally, projecting the resources required to satisfy these problems or take advantage of these opportunities.

6.4 PHASE 2 HISTORY, MARCH 1972 TO APRIL 1973

In Phase 2, the Drew School moved on to make basic decisions on programs, while the consultants increased their emphasis on fostering the creation of decision-making processes. These changes reflected in part changes in the make-up of the consulting team.

At about the time of the transition from Phase 1 to Phase 2, the last major departmental chairmanship in the Drew School--Medicine--was filled. Community pressures were intensifying around the selection of a dean for the school of allied health and the position of ombudsman. The idea of a board of visitors was under discussion. Drew had an annual budget of well over \$1 million and had gone far toward taking shape as an institution.

In March 1972 the initial Phase 2 meeting between the consulting team and Drew representatives was held to discuss the forthcoming program of work. It was also agreed that the member of the consulting team responsible for the program development effort would spend essentially full time at Drew during the summer and fall months of 1972. Experience indicated in general that lack of consultant "presence" had been a significant drawback in the first phase of the study, and the budget arrangements for Phase 2 were worked out accordingly.

Phase 2 work by the consultants began in April 1972 with a study to develop a first approximation of a more effective administrative (dean's office) organization for the Drew School. The work process for this task involved individual interviews by the consultants with the dean, department chairmen, administrative assistants and secretaries to the dean, and personnel in what was at that time the office of the controller. The discussions focused on the administrative needs of the persons interviewed, the issues they saw at that time as important to the development of Drew, and the directions in which they felt Drew should move.

This preliminary administrative organization study took about a month to complete and resulted in a short written report to the dean recommending, among other things, the establishment of a planning and development function, upgrading the position of controller to director of administration and finance, and expanding his office to provide more accounting support. The study also had other important effects. It enabled the consulting team to re-establish contact with the department chairmen. It enabled current issues to be identified and discussed mutually by the consultants and those interviewed. One basic issue mentioned by nearly everyone interviewed was the lack of a shared, clearly articulated mission for the Drew School, and, in that absence, the fact that faculty members seemed to be pursuing their own individual and departmental objectives. Awareness of this issue set the stage for the subsequent survey work among the faculty.

After a break of about a month, during which time contract approvals were taking place with BHME, the real work on program development began in June 1972. The Master Plan consulting team, in consultation with the dean of the Drew Medical School, decided that a written survey of the faculty should be conducted to obtain a comprehensive view of the attitudes of the faculty and professional staff on key issues relating to Drew's mission and future development. (See Appendix 3.) It was also decided to administer a second questionnaire to the department chairmen to obtain an up-to-date and standardized accounting of current activities and of plans and strategies for the future in each department. These data were viewed as basic information needed before any significant program development process could be initiated.

Also in June 1972, the Master Plan consulting case team was reconstituted. During the preliminary Phase 2 interviews with faculty members, the issue of the racial composition of the consultant team was raised. In Phase 1 and up to that point in Phase 2, the consulting team was mostly white. The new consulting team formed in June had four members: a black assistant professor from the UCLA School of Architecture and Urban Planning who was associated with the Urban Workshop, Inc., of Watts; a black professional from Arthur D. Little's San Francisco office who had previous experience with community action programs; and two white consultants, one from Arthur D. Little's Cambridge, Massachusetts, office and the other from Lester Gorsline Associates. This meant also that three of the four members of the core consulting team were from California. Since the team member

from Cambridge had agreed to spend essentially full time on the scene, all members of the consultant team were readily available to the project, a fact which proved important in maintaining the momentum of the work.

Again in June, the consulting team made two key decisions concerning community participation in the forthcoming program development activities and the consultant's role with respect to community participation. First, the consulting team's client was explicitly identified as the dean of the Drew School, and not the community or faculty or board except through the dean. This decision resolved an issue that had sometimes interfered with the conduct of the Phase 1 work. It made the consultants primarily responsible and accountable to the dean as the officer best able to represent the Drew School as a whole. This accountability was expressed in frequent reporting by the consultants to the dean on the progress of the work and in participation by the dean in the work process. Eventually, as discussed later, the consultants' point of accountability was extended somewhat with the formation of a steering committee to oversee the program development work; however, the basic client relationship remained with the dean.

Second, the consulting team decided not to assume the role of active intermediary between the Drew School and the community, presenting explanations and arguments for Drew's actions to community groups on the one hand and acting as advocates for the community to Drew on the other. Members of the consulting team did meet with community leaders to discuss their perceptions and expectations for the Drew School, but they did not organize community meetings as had been attempted in the first phase.

There were several reasons why the consultants chose not to be active intermediaries. For one thing, experience in Phase 1 of the work showed that community people wanted to deal directly with Drew, not with paid consultants. Drew's administration had to establish its own contacts and its own credibility with community groups. Also, the consultants could not afford to be closely linked to community leaders and risk being seen as advocates of their positions. Such a perception might have raised expectations on the part of the community which the consultants could not deliver and, at the same time, could have seriously undermined the consultants' credibility and objectivity in the eyes of people within the Drew School. Another factor in the decision was limited study funds. Theoretically, the study could have been redefined with the community as client, but to undertake a comprehensive job of community organizing would have required more funds than were allocated for the project. Initially, tentative plans were made for the consultants to do a limited amount of direct work with several housing projects near the Drew School, but the local community-based group slated for that task turned out not to have the requisite credibility in the eyes of the community to actually undertake it.

What the consultants could and did do was to provide vehicles for community participation in program development by recommending that working groups be formed to include community members.

During June and July, questionnaire instruments were developed and refined for the surveys on faculty and staff attitudes and on the activities of each department. (Copies of the questionnaires are included in Appendix 3. Initial drafts of the questionnaires were submitted for comment to the dean and associate dean. The final questionnaires reflected their inputs, and the questionnaire on attitudes accordingly included questions about a health care delivery system and the allied health sciences program.

While the questionnaire instruments were being designed, a member of the consulting team met twice with the faculty executive committee to observe how this group functioned, to discuss the Master Plan Study in more detail, and to obtain agreement from the department chairmen to participate in the survey. The consulting team also met with the chairman of the Drew board of directors to discuss the prospective survey and to obtain his counsel and advice. Approval to proceed with the survey was obtained in July from both the board chairman and the dean, and the survey instruments were administered during that month. The individual questionnaires were, for the most part, administered in meetings with the faculty and staff of individual departments; they took about an hour to fill out. In some cases, copies of a questionnaire were left with faculty members for subsequent return to the consulting team.

The results of the questionnaires were analyzed during July and August, using a computer program developed by the UCLA Survey Research Center. The tabulated results were sent to the faculty during September in a series of "feedback reports," which are included in Appendix 3. These reports were designed to share information among the faculty broadly as a basis for program development. They were also intended to give the faculty some immediate, tangible results of the Master Plan effort. The faculty response to the feedback documents was somewhat disappointing, in that little comment, either positive or negative, was elicited. But the reports did set the stage for later program development by providing the faculty and administration with a relatively clear picture of where the faculty stood on program development priorities; on the basic mission of the Drew School; on activities which should be started, stopped, or continued; and on a variety of other issues.

Also during July and August, the consulting team held personal interviews with members of the faculty, board members, community physicians, and community leaders. These interviews were aimed at obtaining a better sense of how these people viewed Drew's purposes, programs, activities, plans, and manner of operating. A member of the consulting team also attended two board meetings to get a sense of how the board functioned and of some of the issues with which that group was wrestling.

In late August, and in accordance with the original work plan, the consultants recommended that a steering committee be formed, made up of administrative, faculty, and board representatives. The intent was to pull together a group which would represent the key sources of power

in the Drew School and which could therefore spearhead the program development effort. It was felt that none of the pre-existing committees or groups in the Drew School should oversee the program development process, because none represented all the needed sources of power. A new group had to be invented and brought together.

The steering committee was formed in September 1972 and legitimated through appointment of three board members and the dean by the board chairman, election of two of the three faculty representatives by the faculty council, appointment of a representative from the executive committee by the dean, and an invitation by the board chairman to the King Hospital administrator to become a member. The dean and King Hospital administrator were named by the board chairman as co-chairmen of the steering committee. The steering committee was thus constituted to involve major elements in the school actively in the program development process, and to have sufficient authority to get work done. The members of the steering committee are listed in Appendix 1.) Seven are black and the eighth is Mexican-American. The job of the consultants was to design and attend the steering committee meetings, provide relevant information, and press for agreement on program priorities.

At its first meeting, the steering committee decided to invite three community leaders representing well-known interest groups to join the committee, commissioned the dean to tender the invitations, and adjourned to await the attendance of the prospective new members before proceeding with its work. All three prospective members declined, one saying that participation would represent a conflict of interest, another saying that program planning was irrelevant to the areas of chief concern to him (land acquisition and physical facilities), and the third because the other two had declined. Accordingly, the committee proceeded with its original members.

At its second meeting, the steering committee split into two groups to discuss program priorities for the Drew School. The priorities chosen were based partly on information from the faculty survey and partly on the experience and expectations of the steering committee members themselves.

One group assigned highest priority to the development of an improved health care delivery system for the King-Drew service area. The group decided that a properly designed system should include specific provision for high-priority health concerns such as drug abuse and hypertension. This group also listed educational commitments and priorities for the Drew School as follows:

1. Education for interns and residents.
2. Continuing education for health professionals.
3. Pregraduate and postgraduate allied health training.

4. Basic health education for consumers, community groups, public school officials, church groups, clubs, etc.
5. Undergraduate medical education.

The second group agreed upon four high-priority areas of need:

1. Drug abuse and alcoholism.
2. Prenatal, maternal and child care, and family planning.
3. Hypertension and related problems.
4. Health professions training for community residents.

This last area was subsequently modified to focus on postgraduate training for health professionals in the service area, because the question of the deanship of the faculty of Allied Health Sciences was still unresolved. The steering committee felt that it would be inappropriate to tackle the whole area of health professional training until a new dean of Allied Health had been recruited.

After hearing the reports of the two subcommittees, the steering committee as a whole agreed to pursue both the development of a health care delivery system and the four high-priority program areas simultaneously, feeling that the latter could not await the results of the system development effort, which would inevitably be a long and complicated process. The subcommittee which had recommended the development of a delivery system was charged by the steering committee to proceed with its work and to expand its membership as necessary to incorporate relevant points of view. The other subcommittee was charged with forming task groups to investigate the individual high-priority areas and develop recommendations for programs. Both subcommittees were instructed to report periodically to the steering committee on progress and recommended courses of action. From that point on, the steering committee as a whole met only to receive reports and then, finally, to receive the recommendations of the work groups for further disposition.

The subcommittee on health care delivery systems, together with the consultants, started work immediately and met on a weekly basis during October and November, 1972. The consultants developed a bibliography on system models. The subcommittee outlined tentative objectives for a delivery system and identified the key interest groups that would have to be involved in any system devised--consumers, health care providers in the service area, financial intermediaries, and health professionals from the King-Drew complex.

It soon became apparent that the subcommittee by itself could not design a workable system, because so many components of any prospective system were outside of its control or influence. It chose instead to

design a process by which system parameters could be determined. The process would start with a large meeting, a conclave, to which representatives of the major interest groups would be invited. The purpose of this initial meeting would be to identify the needs of these groups which must be met in a delivery system. With that information, system design work could then proceed. With the approval of the steering committee, the conclave was scheduled for the end of January 1973. Arrangements for it were made by the department of Community Medicine, whose head was also the chairman of the subcommittee. An outside group facilitator was engaged and, with his participation and with help from the Master Plan consulting team, planning for the conclave was completed.

Meanwhile, the subcommittee on program development drew up preliminary lists of names, both in the Drew School and in the community, to make up task groups for each of the four program areas: drug and alcohol abuse, hypertension and related problems, maternal and child care, and postgraduate training for health professionals in the service area. Individual subcommittee members were assigned people to recruit. The first meetings of the task groups were held on October 31 and November 1, 1972. Each subcommittee member took charge of one of the task groups, and members of the consulting team were assigned responsibility to work with specific task groups. Scheduling and clerical support was provided by the office of the dean. Task groups met, on the average, about seven times for periods ranging from one to five hours. The recommendations they produced are in Appendix 2 and constitute the product of the Master Plan program development effort--a series of program recommendations representing school-wide priorities. The overall process directly involved a total of about 50 persons, 25 of whom were from the community.

Several other events took place while program development was going on. First, as a result of an earlier contact by members of the consulting team, the dean and a member of the consulting team were invited to meet with the Agency Executive Advisory Committee of the south-central Los Angeles area on September 26, 1972. The meeting was attended by some 45 representatives of various social service agencies in the south-central area. At the meeting, two people were identified who were invited to be active participants in Drew's program development process, and a major community concern--more humanistic health care--was clearly voiced by the attendees.

Second, during the latter part of 1972, the consulting consortium was busy working out its own roles and internal relationships. Agreement was reached that the Urban Workshop would take on the specific task of developing information on the service area to supplement the work of the task groups, especially in the area of drug abuse, and would, by so doing, train several of the young community residents who were associated with the Urban Workshop. Representatives from Lester Gorsline Associates, while viewing their primary task as the development of a preliminary physical plan for the Drew School and an estimation of the associated resources required, would actively work with the steering committee and with the

task group on hypertension. The Arthur D. Little team, together with Dr. Eugene Grigsby, assistant professor of urban planning from UCLA and affiliated with the Urban Workshop, continued to have program development as its primary responsibility and took responsibility also for developing the ongoing planning mechanism for the Drew School, one of the five principal tasks in the original work plan. This clarification of roles enhanced the ability of the consulting team to operate smoothly together.

Third, the Lester Gorsline Associates team developed the basic information it needed to make estimates and projections of the facilities, funds, and manpower which Drew would require. It did so by drawing on three basic sources of information: the results of the program development process, discussions with the dean and several department chairmen, and from their facilities design experience built from past work in other settings.

On January 27, 1973, the conclave designed by the subcommittee on health care delivery systems was held at the John Locke High School. It was attended by over 100 persons and included small and large group discussions aimed at generating agreement on the needs and concerns of each major interest group which the delivery system would be designed to meet. The conclave directed the subcommittee to move ahead on system design and to report back to the participants in about six weeks. The subcommittee agreed to add interested community residents to its membership to broaden the planning base.

On February 12, 1973, the steering committee met and agreed to forward the recommendations of the four task groups and the subcommittee on health care delivery systems to the board of directors, thus validating the work of these groups and taking the step necessary to inform the board of the steering committee's work.

On February 14, 1973, the board of directors at a regular meeting agreed in principal to establishing an office of director of planning and development in the Drew administration, the job description for which had been recommended and drawn up earlier by the consultants and submitted to the dean.

The consultants began to prepare their report in December 1972 and presented the final draft to the Drew School at the end of February. After review and final revisions it was accepted by the Drew administration as embodying the Master Plan called for in the contract with the Bureau of Health Manpower Education.

6.5 PHASE 2 EVALUATION

The Phase 2 work proceeded essentially as originally planned. There were some deviations from plan, notably the fact that the entire faculty did not review the program development results prior to approval. However,

that deviation was the result of an explicit decision by the steering committee to forward the task group reports directly to the board rather than go through an exhaustive faculty review process which was not feasible because of the press of time.

The basic study model, which involved interviews; surveys; feedback of survey results; formation of a steering committee representing the key sources of power in the situation; establishment of task groups involving still more people; and the production of recommendations on programs, facilities, and administrative change was proven to be essentially sound. The use of outside consultants to supply energy and direction to the process (in addition to their technical role in relation to facilities) was undoubtedly required. The consultants' sole job with respect to Drew was to work on the Master Plan Study. To the Drew administration, faculty, and board, this study was only one of many preoccupations.

The steering committee/task group process produced tangible and significant recommendations. The process of interviewing and surveying by the consultants produced increased clarification of Drew's basic mission and provided perspective on Drew's activities. It was possible to specify the administrative and organizational changes needed to sustain an ongoing planning process in Drew after the Master Plan Study itself had terminated. And, finally, on the basis of the program development work and interviews with faculty and administration, it was possible to sketch out the resources and physical facilities which would be required for Drew's development over the next few years.

On the minus side, attendance at steering committee meetings was less than the consultants hoped for. Also, community representatives who were invited to participate on the steering committee declined, leaving board members to fill the community role. The task groups did not develop their recommendations to the point where specific proposals could be made to funding agencies, though this is perhaps understandable in view of the limited amount of time available and the charge given to the task groups.

One of the most significant areas where improvements could have been made was in the level of contact between the Master Plan consulting team and the faculty (particularly the department chairmen) and board. To be sure, some board members and department chairmen were members of the steering committee and kept abreast of the work as it progressed, as did the dean and the King administrator. But many board members and chairmen were not involved directly in the process and probably lost touch with the work.

In addition, the amount of consumer representation and consumer involvement in the program development process was somewhat less than hoped for. While the task groups did incorporate a number of people from the service area, most of those people were directly connected with agencies and organizations and very few were "pure" consumers.

ED 078795

Master Plan

for the Drew Postgraduate Medical School Los Angeles, California

To Bureau of Health Manpower Education, March 1973

Contract NIH 71-4149

Volume 3: Appendix

**Lester Gorsline Associates
Arthur D. Little, Inc.
Urban Workshop**

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Names of Participants
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APPENDIX 1: LIST OF PARTICIPANTS IN THE MASTER PLAN STUDY

Persons Interviewed During the Course of the Master Plan Study

Joseph Alexander, M.D.	Chief, Department of Surgery Charles R. Drew Postgraduate Medical School
Elias Amador, M.D.	Chairman, Department of Pathology Charles R. Drew Postgraduate Medical School
Mary Ashley	Department of Community Medicine Charles R. Drew Postgraduate Medical School
Norman Barker	Board member; President, United California Bank
Devra Breslow	Assistant to the Dean for Public Information Charles R. Drew Postgraduate Medical School
Charles Brown, M.D.	Board member; Assistant Medical Director Martin Luther King, Jr., Hospital
Charles Buggs, Ph.D.	Former Dean, Faculty of Allied Health Sciences Charles R. Drew Postgraduate Medical School
John Campbell, M.D.	Chairman, Department of Radiology Charles R. Drew Postgraduate Medical School
Alfred Cannon, M.D.	Chairman, Department of Psychiatry Charles R. Drew Postgraduate Medical School
Ginney Carpenter	Secretary to the Dean Charles R. Drew Postgraduate Medical School
Eleanor Carper	Administrative Assistant to the Dean Charles R. Drew Postgraduate Medical School
Myrtle Caton, M.D.	Associate Professor, Department of Community Medicine Charles R. Drew Postgraduate Medical School
Ezra Davidson, M.D.	Chief, Obstetrics and Gynecology Charles R. Drew Postgraduate Medical School
Morris Davidson, Ph.D.	Consultant, Allied Health Sciences Program
Leroy W. Demery, M.D.	General practitioner, south-central Los Angeles
S. Randolph Edmonds, M.D.	Assistant Professor, Department of Pediatrics Charles R. Drew Postgraduate Medical School

APPENDIX 1: LIST OF PARTICIPANTS IN THE MASTER PLAN STUDY

Persons Interviewed During the Course of the Master Plan Study

Doris Fuller	Board member; community resident
Johnn Fullmore, Jr.	Director, Administration and Finance Charles R. Drew Postgraduate Medical School
Caffee Greene	Chairman, Area IX Regional Medical Program
M. Alfred Haynes, M.D.	Chairman, Department of Community Medicine Charles R. Drew Postgraduate Medical School
Hubert Hemsley, M.D.	Board member; private practitioner
Julius Hill, M.D.	Board member; private practitioner
Walter Hines, M.D.	Surgeon, south-central Los Angeles
Opal Jones	Community resident
Rory Kaufman	Board member; community resident
Ferdinand Leacock, M.D.	Assistant Professor, Department of Surgery Charles R. Drew Postgraduate Medical School
Martin Leichter, M.D.	Private practitioner, south-central Los Angeles
William Long, Ph.D.	Chairman, Agency Executive Advisory Committee south-central Los Angeles
Sherman Mellenkoff, M.D.	Board member; Dean, UCLA School of Medicine
Alva Marsh, M.D.	Board member; private practitioner
Valentino Mazzia, M.D.	Chairman, Department of Anesthesiology Charles R. Drew Postgraduate Medical School
Lillian Mobley	Community resident
Henry Paul, M.D.	Department of Medicine Charles R. Drew Postgraduate Medical School, formerly a private practitioner in the south-central Los Angeles area
Milton Roemer	UCLA
John Saxon	Vice Chancellor, UCLA

APPENDIX 1: LIST OF PARTICIPANTS IN THE MASTER PLAN STUDY

Persons Interviewed During the Course of the Master Plan Study

Robert Schlegel, M.D.	Professor, Department of Pediatrics Charles R. Drew Postgraduate Medical School
John F. Simmons, M.D.	Private practitioner, south-central Los Angeles
Ernest Smith, M.D.	Assistant Professor, Department of Pediatrics Charles R. Drew Postgraduate Medical School
Phillip Smith, M.D.	Board member; Medical Director Martin Luther King, Jr., Hospital
Mitchell Spellman, M.D.	Dean Charles R. Drew Postgraduate Medical School
Harris Stein, M.D.	Private practitioner, south-central Los Angeles
Marie Stevens	Development consultant Charles R. Drew Postgraduate Medical School
James Taylor	Board member; Assistant Superintendent Board of Education, City of Los Angeles
Daisy Thomas	Staff member, Area IX Regional Medical Program
Dolores Tomlin	Community resident
David Ulmer, M.D.	Chairman, Department of Medicine Charles R. Drew Postgraduate Medical School
John E. Washington, M.D.	Private practitioner, south-central Los Angeles
Ted Watkins	President, Watts Labor Community Action Committee (WLCAC)
Henry Williams, M.D.	Chairman, Board of Directors Charles R. Drew Postgraduate Medical School; private practitioner
Charles Windsor	Administrator, Martin Luther King, Jr., Hospital
Abigail Winge	Board member; community resident
Liston Witherall	Chief, County Health Department County of Los Angeles

APPENDIX 1: LIST OF PARTICIPANTS IN THE MASTER PLAN STUDY

Persons Interviewed During the Course of the Master Plan Study

Alma Woods	Member, Board of Visitors Charles R. Drew Postgraduate Medical School; community resident
Margaret Vail Woolley	Board member; attorney

APPENDIX 1: LIST OF PARTICIPANTS IN THE MASTER PLAN STUDY

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APPENDIX 2

REPORTS OF TASK GROUPS
AND SUBCOMMITTEES

REPORT OF THE SUBCOMMITTEE ON HEALTH CARE DELIVERY SYSTEMS

Health Care System Model

Components of System

Services
Resources (people, money, facilities)
Constraints
Goals
Control
Coordination

I. GOALS

- A. To work with the community to provide high quality health care which is acceptable, accessible, and continuous and which results in an improvement in the health status of the community.
- B. To enable the health care providers to maintain and improve their capacity to offer high quality care.
- C. To demonstrate that an effective health care system can provide services that are economically feasible and acceptable to consumers.
- D. To demonstrate that the educational and training functions of the King-Drew medical center can contribute to the improvement of the health status of the community.

II. PROBLEMS

- A. Poverty
- B. Disease Problems
 1. Mortality: Homicides, accidents, heart disease, early infant diseases, malignant neoplasms, cirrhosis of the liver, vascular lesions affecting CNS, diabetes, influenza and pneumonia, other chronic respiratory diseases.
 2. Morbidity: Trauma, cancer, alcoholism (pancreatitis), drug problems (hepatitis), hypertension, anemia, cervical cancer, prematurity, child abuse, hostility, low level of self-esteem, atypical sex ratio at birth.
 3. Health Care Delivery Problems

III. OBJECTIVES - Related to the Problem of Poverty

- A. Reduce poverty in the community, i.e., raise the median family income in the area to a level of parity with L.A. County as a whole within ten years.
- B. To achieve community control of the dollars spent on health care within five years. (Community is defined to include all component parts of the community - consumers and providers.)

IV. OBJECTIVES -Related to Disease Problems

- A. To decrease the infant mortality in the area to a level of parity with L.A. County within 5 years.

V. OBJECTIVES - Related to Health Care Delivery Problem

- A. To ensure that every family in this community has continuous access to some responsible source of high quality primary care.
- B. To ensure that those who need other kinds of health care are appropriately referred and linked with additional sources of care.

VI. RECOMMENDATIONS

- A. The committee then decided to approach providers, funding agent representatives, consumers and members of the educational institution (King-Drew) and inquire what specific objectives they would like to see accomplished through an HCDS. It was suggested that the way to accomplish this would be through a half-day conference which would have these various people in attendance. These individuals would then have the opportunity to present their ideas for themselves.

Doctors Haynes and Hemsley were particularly enthusiastic about this suggestion. All felt that this activity should take place within the next three weeks, with the consultant team taking the lead in setting up this event.

After considerable discussion, the following format of our services was outlined:

- 1. Comprehensive Medical Services
 - 2. Social Services
 - 3. Educational Services
 - 4. Research
 - 5. Linkage with Economic Development Projects
- CONTROLLED BY
THE COMMUNITY

The above services were felt to be mandatory in order to have an effective HCDS that would meet our goals and objectives. The committee recognized that the following constraints would be operating on this system:

1. Economic
2. Education (counseling)
3. Lack of industry in the area with low utilization of local manpower
4. High resident turnover
5. Funding
6. Transportation

REPORT OF THE TASK GROUP ON POSTGRADUATE TRAINING FOR HEALTH PROFESSIONALS

We hereby submit our findings, conclusions, and recommendations on the Postgraduate Training for Health Professionals as a part of the Program Development Committee's report. The charge to our subcommittee was:

"To recommend to the Steering Committee what programs Drew should mount in the area of concern to the Task Group, building on and taking account of program activities already underway or planned."

The committee was intended to be composed of individuals from both the MLK-Drew complex and the service area community. Several people were invited to participate, but due to the time schedule or personal reasons, some were unable to accept or continue their involvement in the work of the committee. They were:

1. Raymond M. Kivel, M.D.
MEDEX-Drew
2. Pauline O. Roberts, M.D.
South District Community
Health Services
3. Ms. Dolores Tomlin
Community Resident
4. Ms. Carol Simpson
Community Resident
5. Miss Beverly Wong
X-ray Department
Co-Health Department
6. Charles Brown, M.D.
Community Physician
Director of Professional Education

We regret their absence, especially the community residents and the possibilities of broader ranges of input from the practicing health professional. Based upon their absence, the committee recognizes the limitations of these findings.

The first of six (6) meetings was held October 31, 1972. At this meeting the tasks and responsibilities of the committee were detailed and discussed. Key elements of the charge and of this report, i.e., definitions, goals, and operating objectives and philosophy, were focused on immediately and continued to be concerns throughout the subsequent meetings. Throughout the meetings, however, it was difficult to have the full range of views and capabilities in the health professions' training needs because of conflicts with members' regular schedules.

I. Definitions

One of the continuing items under discussion was the meaning of several words. The primary emphasis in determining the relative meaning of specific words was to ensure that the intent and meaning reflected the directions and goals of the MLK-Drew Complex. Further, it was hoped that the ultimate definitions would clarify the relationships of various roles and the effect these terms or words could have on attitudes and team building. The "team" emphasis should be reflected in all the aspects of the patient/health relationships. Even though comprehensive definitions must be developed for health services, medical care, and patient (as the central figure and a participant in his care), it was felt necessary to define the following before proceeding:

- a. Postgraduate professional education refers to the education of health care personnel beyond the initial skills level. It is . . . "the category for which at least baccalaureate preparation is appropriate; includes occupations for which the level of education may be the bachelor's, master's or doctoral degree; internship or residency training; or post-doctoral training." ¹
- b. Allied Health. It is . . . "occupations for which the appropriate basic preparation requirement is less than baccalaureate; the level of formal education may be an associate degree, diploma, or certificate, or none of these." ²

II. Goals

Since the trained health professional is one of the main keys to meeting our community's health needs and problems, it is imperative that the existing skills and techniques are kept current relative to technological advances in health care. There is increasing need to be aware of major changes in the organization of health care delivery, which are stimulated by the community's demand for comprehensive health care services.

There is a need to fashion continuing measurable education goals in order to achieve and evaluate effective results.

Serious consideration must be given to the changing or modification of the school's name so that the label reflects what the school is established for and does. Postgraduate efforts are not all of the functions.

1./ Report to the President and the Congress--The Allied Health Professions Personnel Training Act of 1966, as amended. U.S. Department of Health, Education, and Welfare.

2./ Ibid.

The goal for postgraduate training of health professionals for the MLK-Drew Service Area is to provide continuing education opportunities in all segments of the medical and health care activities so that the following objectives are met:

- Maintain and increase the range of skills and access to current information for the community physician and other health professionals.
- Improve utilization by providing current information on changes in health care organization, its uses and services, and the distribution and utilization of specialized manpower to both providers and consumers.
- Develop courses that focus on humanization of health services - e.g., increase the emphasis on (a) the equity of health care delivery, (b) the individual's ability to actively participate, and, (c) recognition of and respect for cultural differences.
- Form relationships with and/or complement other community health and related programs which are consonant with the philosophy and objectives of Drew's postgraduate education programs.
- Provide encouragement to community residents to enter the various health professions by ensuring access to professional training opportunities and assisting residents to understand and to relate to the diversity and the advantages of the health profession.³
- Improve the community's overall health manpower skills by including comprehensive, relevant research in the preventive and therapeutic programs so that they are accountable, acceptable, and have major impact on the health needs of the area.

III. Findings and Recommendations

1. That the concepts and programs, as presently operated, tend to separate the two institutions rather than build in the "team effort" based upon attitudes of cooperative energy and recognizing that together there are mutual goals and linked responsibilities.

3./ This is to provide a full range education. Part of the spectrum is the entry and the other part of the spectrum is the practicing person. Both need continued involvement with each other. The statement is included to insure the area is considered when the programs are being planned.

Recommendation: There must be a working out, and planning of ways for an individual, departments, and/or programs to come together. Active attention must be given to preventing the separate feelings, attitudes, and fragmented organizational resources consideration of the following:

- Joint departments and interdepartmental meetings of groups with similar and dissimilar interest at the two (2) institutions. The aim is to not let tasks get in the way of collaboration efforts and overall goals, comprehensive and adequate care. There should be alternation of the meeting places between the two institutions.
 - Having the program training departments of the two institutions develop a program for all new and old employees relating to and dealing with the role changes required to provide team services in a humane and efficient manner.
 - Accepting onto the faculty at MLK-Drew any person who teaches there full time.
 - Recognizing that there are differences in the two institutions for control and responsibility - that there is a possibility for joint efforts; and ultimately the Christmas parties will be as much concern as is the latest drug, machinery, or surgical procedure.
2. That there is no coordination, relatedness to the organizational structure, or linking of the various continuing education programs within the MLK-Drew complex. For example, there are at least seven (7) projects, programs, courses, workshops and/or seminars being given; yet who is doing what, when, where, for whom is not centrally known by any one department or person.

Recommendation: There must be a sphere of definable influence that is felt and/or created by both the present and future activities of the MLK-Drew complex. The traditional methods and/or models will not be accepted. An institution dedicated to a new process cannot achieve it by the old or traditional techniques. To try it is a contradiction and will only result in failure. For example, the term allied health, by its connotation, creates an environment of in and out process and subordinate stature rather than a building of the collaborative skills. Factors to be considered in developing models and programs that will enhance the primary purpose of the MLK-Drew complex are:

- Establishing a vehicle for thorough coordination of programs, both inhouse and for the community, to prevent duplication and fragmented services. This should be a joint program between MLK and Drew.

Some of the initial activities could be:

- Establishing a glossary of terms that reflect and are relevant to the activities and direction of the MLK-Drew complex.
- Establishing criteria and rationale for courses and the intended results relative to education and/or training in continuing education.
- Establishing regular meeting for all continuing education and/or training personnel to come together to exchange information, develop a master calendar of events, and assess the needs and/or resources for each.
- Establishing a balanced program of continuing education for the community health professionals, the MLK-Drew personnel, and others outside the service area. Priority must be given to community health professionals.
- Establishing an open communication policy and a mechanism for advising all interested persons of the type of classes being presented.

3. That of the various continuing education and/or training activities within the MLK-Drew complex, a very small percentage are oriented to the community practitioner.

Recommendation: That there is a need for constant, aggressive, and active attention to involving the community physician into the full growth and development of all aspects of the MLK-Drew complex. We must recognize that the multiplicity of the goals and the separate responsibilities of the two entities need not exclude the utilization and participation of the community physician. The community practitioner must be utilized as teacher and practicing staff member of the hospital. The following suggestions are aimed toward getting the two, MLK-Drew and the community physician, together:

- Develop a mechanism and instrument which can be utilized by both institutions for assessing the interest and acceptance of community physicians into the faculty and/or medical staff.
- Develop other ways and opportunities for community physicians to participate if not interested in teaching or being on the medical staff.
- Recognize and accept the available financial and advocate support through the concern and dedicated interest of the community physician.

IV. Philosophy

This report of the committee's work reflects the limited time and resources available to address the task. The committee feels that it is more important at this time and instant to develop ideas about process and the overall frame of reference in which to set specific programs. Clearly, there are many specific needs and it's fairly easy to develop lists, recognizing that resources and preferences will automatically define limits on final programs for implementation. But, without a clear over-allness from which to start, unnecessary chaos, conflict, and a lack of services are inevitable. As the committee attempted to execute its tasks, we found fragmentation in operation and lack of collaborative efforts in uniting the two institutions.

REPORT OF THE TASK GROUP ON HYPERTENSION

The task group on hypertension and related problems has held three meetings to formulate recommendations for program development. The task group's work is summarized below in three sections: (1) Statement of the Problem, (2) Recommended Programs, and (3) Priority Considerations. A list of members of the task group is to be found in Appendix 1.

I. Statement of the Problem

Although hard statistical data on the service area is lacking, it is estimated that the incidence of hypertension may run as high as 30% of the adult black population. The hypertension clinic is the busiest specialty clinic in Martin Luther King Hospital. The problem is further complicated by the fact that the disease is asymptomatic for the first ten years or so. Even though it can be identified early through screening, it is difficult to manage because patients tend not to continue taking medication in the early stages of the disease when they are not experiencing symptoms of pain or discomfort. Hypertension is one of the few diseases which can be kept under control and even cured in some cases if diagnosed early. Later complications of hypertension, including stroke, heart disease, and kidney failure, can be avoided with early intervention and continuous treatment. In short, it is a disease which attacks a very significant number of people in the service area, and in which medical science can actually accomplish effective intervention and control with current techniques.

II. Recommendations

- a. The task group recommends that Drew School undertake to provide a broad base of support for the program being mounted by the department of Medicine for the training of community health workers in the area of hypertension. It should be noted that this is a pilot program, involving the training of about six community health workers, to serve as a model for larger future programs. The workers will be trained to teach the public about hypertension, to take blood pressures, and to keep records identifying individuals who may have hypertension. The present plans are to begin the initial phase of the program in the spring of 1973. Drew's commitment is to assume an essentially educational responsibility, leading the way and developing a model rather than attempting to take on a community-wide responsibility that is beyond its resources.

The task group on hypertension further recommends that a medical social worker be included in the initial team. In addition, it would appear advisable for the school to make available the services of a professional educator whose expertise would apply not only to developing programs in hypertension and related problems, but to the entire spectrum of the education of community health workers.

The task group has been informed that the RMP is currently considering the allocation of \$300,000 to related programs in the Los Angeles area (RMP areas IV, V, and IX) by December 31, 1972. The task group recommends prompt exploration of the possibility of having a portion of these funds allocated to the support of the recommended program, which will be developed within the context of the RMP's overall plans.

Finally, the task group notes that in the development of programs in hypertension, the critical issue is not screening and diagnosis, but follow-up and treatment of asymptomatic cases.

- b. The task group recommends that Drew School provide support for the department of Medicine's proposed program to train approximately four nurses to be assigned as nurse-practitioners in the hypertension clinic. The financial issue raised by this program is that no guarantee exists that salaries for these nurses will be funded by the County. Funds must accordingly be found in sources other than the County system to support these nurses during their training period. It is, however, anticipated that the County will thereafter assume their salary support.

As was the case with the previous recommendation, the nurse-practitioner program is seen as a model, with Drew's function being to provide guidelines for a program which can be generalized by replication elsewhere. (It should be noted that this program is more specifically focused on training in hypertension than is the nurse-practitioner program at the Watts Health Center.)

It is again recommended that the possibility of obtaining RMP funding for this program be explored.

- c. The task group recommends that a general educational program be mounted by Drew School, aimed at making residents of the community more aware of the dangers of hypertension and of its consequences, such as strokes, heart disease, and renal disease. The object of the program would be not merely to create a sense of concern but to motivate people to seek the help that is available.

The task group conceives of a number of different paths along which an educational program might be directed; local schools, churches, community centers, shopping centers, physicians offices, and social clubs represent some of the many paths that exist. (The adult schools are suggested as particularly effective media.)

An educational staff will surely need to be developed, as well as teams of community health workers under the direction of physicians and nurses. In addition, full or part-time positions may be required in the area of media communications--films, radio, and television. Until Drew's and King Hospital's audiovisual resources are more fully developed, help can probably be found at USC and UCLA. It is believed that help can also be expected from the Heart Association.

- d. The task group recommends that Drew School undertake to apply its resources to creating an information system which will provide physicians and other health professionals in the community with useful and timely data in regard to hypertension. The basic parameters of hypertension are well known; the need that exists is in making information available promptly and in the most useful form.

The task group foresees useful applications of such a system in identifying high-risk patients, in following up patients after diagnosis, and in providing physicians with information about drug usage.

- The task group recommends that in developing its Learning Resources Center, Drew School provide for both the technological and human resources for such an information system. At the outset such hardware resources should include data processing equipment and computer terminals on a time-share basis; the human resources should include programmers oriented toward health care systems.

III. Priority Considerations

In considering the priority ranking of these four recommended programs, the task group notes that the implementation of the fourth and last program is linked to the development of the Learning Resources Center.

Assigning priorities to the first three programs raises questions to which the task group is not prepared to make a final recommendation. The questions are these: Should a broad educational program focused on arousing motivated concern among residents of the community be delayed until the resources are ready to cope with this concern and the increased number of hypertensive patients? Or should an educational program begin as soon as possible, with the increased level of concern acting as a stimulus to the mobilization of resources?

The task group suggests that achieving a balance between education and resources for treatment represents a basic problem to which further thought must be given.

REPORT OF THE TASK GROUP ON MATERNAL AND CHILD HEALTH DEVELOPMENT

The goal is to build an organized system of health services for mothers and children in the MLK-Drew Service Area. The organized system should include a strategy to coordinate and link the existing facilities, programs, and related health services. The strategy of integrating health services should be an on-going process and the "real" basis for services will come from education and research activities. The emphasis should be to implement programs in medical training facilities that will develop personnel to function and work effectively in the community setting.

I. Criteria

In order to build a system of health services and to make rational judgments about each of the components, the decisions must be based upon how a particular program fits into the overall goals established for providing maternal and child care services. The following elements should be incorporated, where feasible, into each sub-system:

- a. locating the program activity where the people and the problem occurs
- b. establishing vocational training for community residents in health and health-related fields
- c. providing measurable objectives for research and development
- d. insuring ethical guidelines to avoid individual interest rather than community need
- e. providing direct services in a humane and compassionate manner
- f. insuring joint participation of related departments
- g. including all allied health fields related to the program
- h. providing mechanisms for consumer advocacy made up of community residents

II. Program Priorities (see attached)

Maternal and child health programs to be recommended as top priority for support.

- a. Child care center - 24 hours for: employee and inpatient mothers - components: employment, education, health

- b. Comprehensive programs of "Family Life Education" - for maternal and child health patients and for the community at large with special emphasis on prevention and self-help
- c. School health and learning disabilities
- d. Comprehensive programs of health for teenagers (including but not exclusive of pregnancy)
- e. Gangs
- f. Maternal and child care research and development components:
 - develop and implement improved policies and procedures for maternal and child care services in the King Service Area.
 - expand the uses of medical procedures which assess fetal growth, development and well being
 - design and implement a common obstetrical and common pediatric record, storage, and retrieval system encompassing the participating providers of care in the King Service Area
- g. Systems of fetal intensive care in the King Labor and Delivery unit with emphasis on better sensing techniques and improved data acquisition, storage and analysis technology

III Recommendations

That Drew should establish a permanent Program Planning and Review Division. The primary function of this division, through a committee, would be to review programs, program criteria, goals and objectives on a regular basis. As an example, the Program, Planning and Review Committee would be responsible for taking the programs from each Department and reviewing it relative to the direction, needs, and relevancy as stated in the goals and objectives. The Program, Planning and Review Committee should be made up of equal representation from: Drew School, MLK Hospital, and residents from the MLK-Drew Service Area.

Discussion, in support of this recommendation - OB/GYN's programs should be reviewed re: Are they meeting the needs of the residents? The major problems as expressed by residents about the OB/GYN are: (1) Waiting time of about 4 1/2 hours, and the way individuals are treated (this may be linked to the problem of broken appointments within that OB/GYN Department). Further, a second problem of incomplete records suggests that alternatives through review and evaluation of the present record system must be done. It appears that the situation is a two-way problem.

IV. Chart

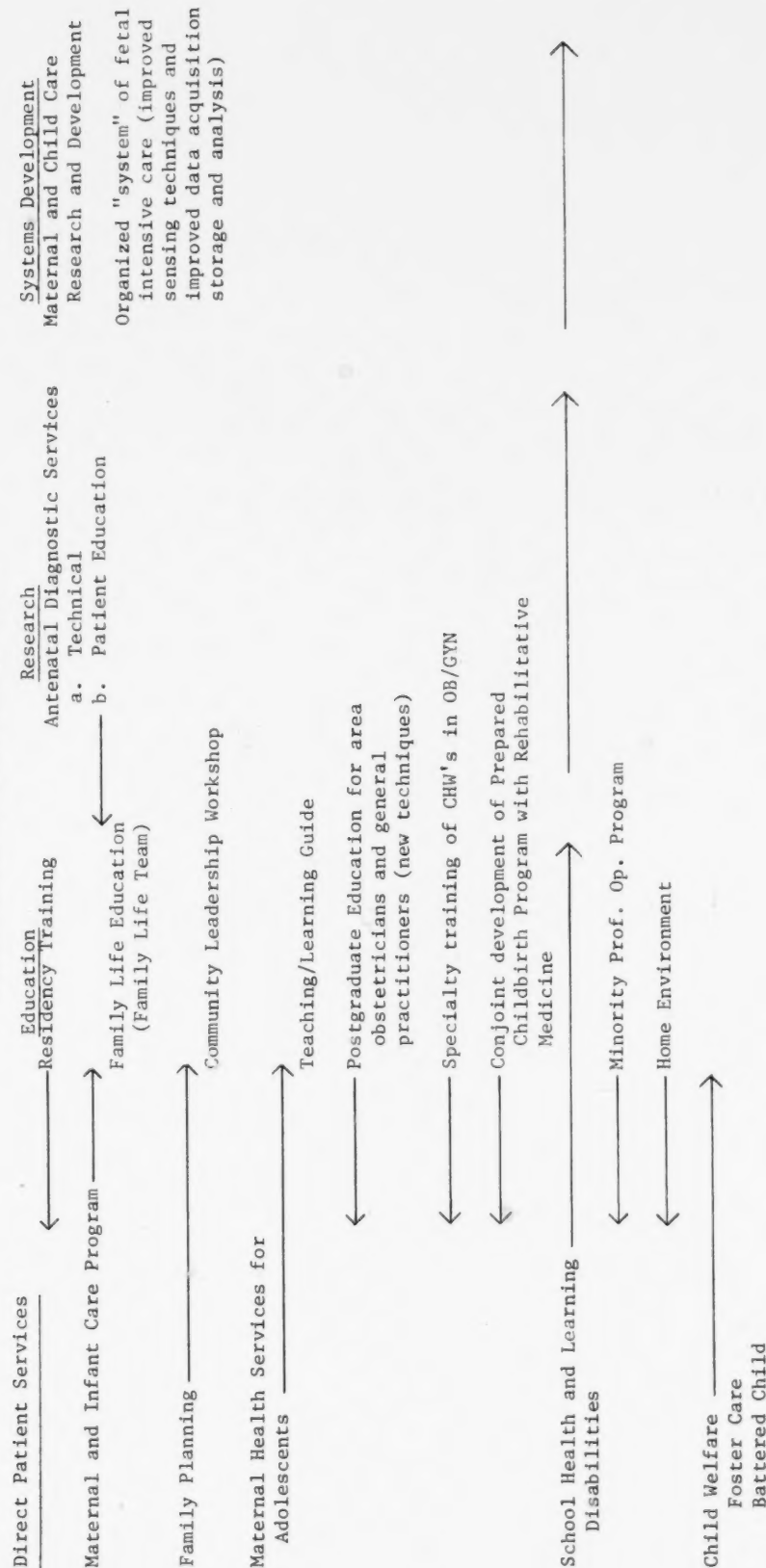
- a. The arrows should not be directed to a specific program but rather to a blank space.
- b. Under "Systems Development"

Maternal and Infant Care System

MIC occurs under Direct Patient Services and the system part is included under Maternal and Child Care Research and Development

Uniform record keeping is also included under Maternal and Child Care Research and Development

II. PROGRAM CLASSIFICATION
MATERNAL AND CHILD HEALTH SUB-SYSTEMS



REPORT OF THE TASK GROUP ON DRUG ABUSE AND ALCOHOLISM

I. Goal

The goal is to work toward a significant reduction of drug and alcohol abuse within the MLK Service Area over the next five years.

The problem of drug abuse and alcoholism is recognized by the Task Group to be a widespread health problem throughout the Service Area. The Task Group also recognizes that solutions, particularly in the area of drug abuse, are extremely difficult; and, in some instances perhaps impossible to come by. Nevertheless, Drew, in meeting its responsibility to the community, should devote time, energy, and resources in attempting significantly to reduce drug use and alcohol abuse within the MLK Service Area.

II. Criteria For Programs

Each program for the reduction of drug and alcohol abuse should employ the following criteria:

- a. Should reflect and take into account the life style in the service area
- b. Represent a unique contribution to the reduction of drug and alcohol abuse, not just a rehash of what is already in operation in the community
- c. Have built-in means for the evaluation of effectiveness
- d. Have goals which are measurable
- e. Should be aimed primarily at the teenager and young adult who are not "hard-core" users
- f. Should not represent stop-gap measures; should be designed to be long-term efforts

III. Recommendations

- a. Drew should develop drug and alcohol abuse education programs aimed at users and potential users, parents and educators, law enforcement officials, physicians, and political leaders. The education programs should provide factual information on the extent, dangers, and consequences of drug and alcohol abuse, and should, in particular, sensitize parents, educators, law enforcement officials, physicians and political leaders to the part they play in contributing to the problem and how they might contribute to a reduction of the problem.

- b. Drew should undertake the development of alternative activities to drug usage. Specifically, Drew should not be involved in methadone maintenance. Rather, Drew should develop programs aimed at youth development, employment opportunities, parental support, developing support mechanisms such as halfway houses and family centered counseling services to help the young user break his dependence on drugs, and persuading law enforcement people not to arrest users when they are referred for treatment. The programs being developed in the Department of Psychiatry appear to be consistent with this recommendation.
- c. Drew should actively develop a mechanism to coordinate ongoing activities by providing information on available treatment programs, where openings are available for the treatment of users, and a forum for bringing together persons engaged in drug and alcohol abuse treatment and rehabilitation efforts to share their experiences and learnings. The Task Group has learned that county drug abuse prevention people would be interested in participating in such a forum.
- d. Drew should establish, in the context of the MLK Hospital, a detoxification program. This program should link, through referral, to treatment and rehabilitation programs in the community so that the user is not just thrown back into the community to repeat his experience.
- e. Drew should research options to existing treatment and educational programs and disseminate the results of this research to the community. In this effort, Drew should become aware of drug abuse prevention and treatment innovations in other parts of the country.

APPENDIX 2

Supporting Information to
the Master Plan Study

Report by

The Urban Workshop, Inc.
1673 East 108th Street
Watts, California

I. LOCAL CONDITIONS - KING-DREW SERVICE AREA

Los Angeles has its share of urban health problems. The Los Angeles Model Cities program, located in the King-Drew service area, is designed to work with problems in the low-income deteriorating urban areas. A planning problem statement of the Los Angeles Model Cities Program relating to health conditions in the Model Neighborhood included the following section:

Neighborhood Health Conditions

In the Model Neighborhood, there are many people whose standards of health are dangerously low. Poor health, mental and physical, lessens the ability of Model Neighborhood children to perform well in school, hampers the adult residents' employment opportunities, and restricts the full enjoyment of leisure time for all. Within the Model Neighborhood, progress in health improvement has not kept pace with the rest of the county. Individual, family, community, and institutional factors still prevent many Model Neighborhood residents from enjoying and benefiting from good health.

Conditions Within the Model Neighborhood As Compared to the County at Large

1. Women have a higher rate of pregnancy complications, and maternal morbidity/mortality

<u>1968</u>	<u>County Ave.</u>	<u>South Health District</u>	<u>Compton Health District</u>
Maternal Death Rates (per 10,000 live births)	2.5	5.8	5.4
Fetal Death Ratios (per 1,000 live births)	12.9	20.7	15.8

2. Infants and children have higher morbidity and mortality rates.

<u>1968</u>	<u>County Ave.</u>	<u>South Health District</u>	<u>Compton Health District</u>
Neonatal Death Rates (per 1,000 live births)	14.2	17.0	14.7
Infant Death Rates (per 1,000 live births)	19.1	26.8	20.5

3. Residents suffer from malnutrition in higher proportions.
4. Residents, especially younger age groups, have higher rates of communicable diseases and lower immunization levels.

<u>Disease</u>	<u>1968 County Ave.</u>	<u>South Health District</u>	<u>Compton Health District</u>	<u>Age Group Most Affected</u>
Syphilis - all stages (per 1,000 population)	80.2	235.9	99.9	50+
Gonorrhea (per 100,000 population)	445.6	1,973.1	727.7	15-29
Tuberculosis - Respiratory (per 100,000 population)	16.7	41.4	14.7	30+
Shigella Infections	11.6	26.7	8.8	0-9

5. Residents of all ages suffer from dental, vision, and hearing disorders in higher proportions.
6. Residents suffer from mental disorders in higher proportions.

Causes
Individual and Family

1. Many residents of the Model Neighborhood lack knowledge regarding available health care programs and procedures; needed services, therefore, often are not provided, and available resources go untapped.
2. Low incomes and poor money-management skills pose financial barriers to preventive and/or minimal health care, and support conditions harmful to good health, e.g., substandard housing, poor diets, and overcrowding.
3. The inadequate family planning, health care, and sex education of many residents have contributed to the health problems in the Model Neighborhood.
4. The inability of many residents to detect health deficiencies before a crisis contributes to the higher morbidity/mortality rates.
5. Model Neighborhood residents tend to place low priority on health care owing to an overabundance of other, more pressing problems.

Neighborhood

1. The life styles of the Model Neighborhood support a subculture in which health care is crisis oriented rather than preventive oriented.
2. Inadequate, inconvenient, and expensive public transportation discourages the use of existing medical facilities and community health programs.
3. The prevalence of low-quality food sold in Model Neighborhood markets contributes to the health problems of area residents.

Institutions

1. Health services for Model Neighborhood residents are fragmented and discontinuous.
2. Specialized and comprehensive family-centered health care programs are inadequate or nonexistent in the Model Neighborhood.
3. Many times the delivery of health services to Model Neighborhood residents is done in such a way as to offend or degrade the

recipient; this in addition to complicated forms to fill out and other procedural requirements, discourages the use of existing health facilities and programs.

4. There is an inadequate supply of doctors, dentists, optometrists, and other medical specialists in proportion to the Model Neighborhood population.
5. Public medical facilities (both for physical and mental disorders) are inadequate, in size and numbers, to provide sufficient health care for Model Neighborhood residents.
6. Health education programs have limited outreach capabilities under present conditions of staff, staffing patterns, and methods.
7. There are insufficient emergency treatment facilities, and insufficient emergency transportation resources in the Model Neighborhood.
8. For those on public assistance, allowances are not adequate to satisfy basic health needs.

In light of the above background information, information relevant to and in support of the work of the four Task Groups established by the Master Plan Study Steering Committee is presented in the remainder of this appendix.

II. DRUG ABUSE

Drug abuse is increasing in the United States. Although this statement is true, it is much too general in nature. For example, the middle-class housewife who takes one of the various sedatives on the market ordinarily would not be considered as having a drug problem. But if we find that she is dependent upon this drug to relax her nerves and help her through her days, weeks, and months, we could, if we wished, state that she has a drug problem.

Consider the person who contracts colds frequently and has become dependent upon medication which contains codeine. He discovers that this medication (drug) also relaxes his body. He then begins to take the drug for this purpose. Is he a drug addict? He passes his discovery on to his neighbors who also begin to use the medication for the purpose of relaxation. Do they have a drug problem?

These factors indicate that "drug abuse" is a definitional problem, the nature of which is at best nebulous in both medical and social contexts. We do, however, perceive that excessive usage of specific drugs is associated with various medical, psychological and social problems; problems which are both harmful to the individual who possesses them and to the society at large who feels the results of his problems. Drug abuse is a problem which affects all of society. The solution is, in part, the responsibility of the society as a whole.

We must first formulate a working definition of drug abuse. Godofsky, when defining the term, states that "drug abuse is considered [to be] (1) dependency on hard narcotic or dangerous drugs (includes the pills, primarily barbiturates and amphetamines), or (2) excessive use resulting in physical harm to one-self or others (overdose, accidents, crime, addiction), or (3) excessive use resulting in social harm (i.e., family), or (4) illegal use of any drug or substance that has resulted in contact with law enforcement agencies."* Godofsky indicates that the latter definition is a pragmatic necessity because most hard data on drug abuse comes from the records of law enforcement agencies. These agencies have well defined legal criteria for drug abuse.

A needed addition to our working definition of drug abuse is a definition of the terms "narcotics" and "dangerous drugs." Turning to Godofsky again, he states that, "The former refers to the natural opiates and their derivatives, both natural and synthetic. Dangerous drugs include all the pills-barbiturates, amphetamines, and LSD providing the bulk of the agents, with other agents also falling into this category." Our concern is primarily with these two categories because they are allegedly the cause of most of the health and social problems associated with drug abuse, i.e., drug addiction and criminal activity.

*Irvin Godofsky, "Assessment of the Problem of Drug Abuse Within the Martin Luther King Service Area," September, 1970.

The Godofsky study found that there is a problem of drug abuse within the King-Drew service area. Some of the data from his study are listed in the following tables:

Table 1

Incidence of Narcotics Violations
Per 1,000 People

	<u>1965</u>	<u>1966</u>	<u>1967</u>	<u>1968</u>	<u>1969</u>
Newton & 77th	4.8	5.5	8.8	11.3	15.5
L.A. City	2.5	3.3	5.0	7.31	10.0

	<u>1965-66*</u>	<u>1966-67</u>	<u>1967-68</u>	<u>1968-69</u>	<u>1969-70</u>
Firestone (unincorporated areas not in- cluding Carson and Cudahay)	1.7	1.9	2.2	3.8	9.3
L.A. County	1.8	2.8	4.9	6.7	8.8

*Fiscal years

Table 2

Incidence of Drug Related Cases Based on
Court Referrals for Adults and Juveniles - 1969*

Probation Department Statistics

	<u>Number of Drug Cases per 1,000</u>	<u>Number of Total Cases per 1,000</u>
King-Drew Service Area	2.7	20.1
L.A. County	1.4	9.14

*Population based on L.A. County Health Department Population Report,, July 1968. L.A. County = 7,199,041. Population King-Drew service area combined census tracts = 330,028. This data is specific for the census tracts within the MLK Hospital service area.

These data show quite clearly that the incidence of drug arrests per thousand people in the years 1967-1969 is consistently higher within the King-Drew service area than in the remainder of Los Angeles. There are various problems associated with the interpretation of these statistics. Some of these problems will be discussed at a further point in this report. One deserves immediate discussion, however; what kind of drugs were involved? If the persons arrested were found to be in possession of marijuana, they clearly do not fall within our definition of narcotics and dangerous drugs users. And, therefore, do not fit the profile of our health and social problem persons --- drug abuse derived. The Golodofsky study indicates that, "unanimous consensus, both empirical and objective, is that the major problem in terms of numbers involved is the use of the dangerous drugs."* These statistics also point to this fact:

*This statement is based on records obtained from L.A.P.D., L.A. County Sheriff's Department, Probation Department, discussions with probation officers, personnel of drug clinics (Nhuru and Bridgeback), county health officials, and officers in the Narcotics Division of the L.A.P.D. and the Sheriff's Department.

Table 3

Number of Court Referrals Associated
with Drug Law Violations - 1969

Probation Department Statistics

Adults

	<u>Total</u>	<u>Male</u>	<u>Female</u>
Total Number of Cases - L.A. County	32,866	28,288	4,578
Total Number of Cases - King-Drew area*	3,328	2,844	484
Number of Drug Cases - L.A. County	7,747	6,728	1,019
Number of Drug Cases - King-Drew area	705	619	86

*Based on data limited to census tracts within King-Drew service area

Table 4

Juveniles

	<u>Total</u>	<u>Male</u>	<u>Female</u>
Total Number of Cases - L.A. County	32,979	24,375	8,604
Total Number of Cases - King-Drew area	3,314	2,621	693
Number of Drug Cases - L.A. County	2,624	2,295	329
Number of Drug Cases - King-Drew area	188	172	16

Table 5

What is Being Used: L.A. as a Whole

Juvenile

	<u>1965</u>	<u>1966</u>	<u>1967</u>	<u>1968</u>	<u>1969</u>
Total Arrests	1,274	1,964	4,010	6,216	7,840
Marijuana	739	1,522	2,910	2,472	2,446
Heroin	15	32	23	56	69
Dangerous Drugs	520	397	1,062	3,684	5,323
LSD		13	15	4	2

Adults

Total Arrests	21,974
Marijuana	7,594
Heroin & Other Narcotics	3,948
Dangerous Drugs	10,432

These data indicate that there is a changing pattern in the drug use habits of juveniles. There is an increased use of pills. This may be so because pills are readily available, in particular Seconal, and, therefore, their use is widespread.

Our primary concern, however, is with the hard drug user within the King-Drew service area. The following information is adopted from the Godofsky study. It provides us with information compiled in a study by the Southeast Health Center Walk-in Drug Clinic. It provides a detailed look at the heroin

addict in the King-Drew service area. The sampling consists of the total clinic population during four days of May, 1970. It should be made clear, however, that although the clinic is located within the King-Drew service area, it does not restrict its services to people who live in that area. Therefore, the following statistics include some persons who live outside of the area of our concern. Nevertheless, we believe that the profile drawn from these data are representative of the heroin addict within the King-Drew service area. The self-explanatory profiles of both males and females are as follows:

	<u>Male</u>	<u>Female</u>
Ages	1.6% were less than 21 26.9% were between 21 and 30 45.2% were between 31 and 40 24.7% were over 40	45% were between 21 and 30 50% were over 30
Ethnic	66.1% were black 28.0% were Mexican-American 5.4% were white	81% were black 16% were Mexican-American 3% were white
Family Status	38.9% were married 37.8% were single 23.2% were separated or divorced	32% were married 32% were single 36% were separated or divorced
Number of Dependents	28.6% had no children 43.2% had 1 to 3 children 13.0% had over 4 children	66% had at least one child and most had more
Habit Size	31.9% spent between 0-\$25 36.8% spent between \$26-50 23.2% spent between \$51-100 6.5% spent over \$100 2.6% did not answer	Majority (60%) spent less than \$50. The rest spent between \$50-\$100.

Male

Female

	About 50% started using heroin between ages 15-19, and another 45% started using it between 20-29	
	31.4% claim to have been hooked between 15-19	
	49.2% claim to have been hooked between 20-29	
	16.2% claim to have been hooked after age 30	
Reasons for Coming to Clinic	23.7% had no money 19.5% had been busted 30.5% had family pressure 26.3% had other reasons	20% had no money 11.6% had been busted 45% had family pressure 23.3% had other reasons
	Almost 100% were involved with other drugs with the majority using alcohol, barbiturates, and marijuana.	All used other drugs concurrently with the vast majority using barbiturates, speed, and marijuana.
Employment	65.8% were unemployed 59.1% felt they lost job because of drugs 76.5% were trained for job	82.9% were unemployed 61.7% felt they lost job because of drugs 63.8% were trained for some type of work
Return Rate	4 out of 186 returned more than 5 times 113 out of 186 did not return Rest came between 1-3 times	Only 1 out of 47 returned more than 5 times 44.6% did not return

From this profile, it is clear that the average heroin addict (in this study) is over thirty years of age, black (70%), has more than one child, is unemployed, has an extremely expensive heroin habit, came into the clinic because of family pressures, and seldom returned.

Drug Programs and Services Available to the Residents of the King-Drew Service Area

The Godofsky study gives such an adequate and personalized description of these programs that his descriptions have been quoted in total:

Currently within the practical availability of the MLK service area, there are three active programs working with individuals with drug problems (mostly heroin addicts). These are the Southeast Health Center Walk-in Drug Clinic, the House of Uhuru, and Bridgeback. All are relatively new, work with a small clientele, and have a rapid turnover of patients. At this point no one is quite sure what an effective drug program entails, and, like religions, each approach is defended vehemently as "the only way" by its proponents.

Southeast Health Center Drug Clinic

This clinic, located at 49th and Avalon, has been operational since March 1970. It is open every day but weekends from 2 p.m. to 10 p.m. and is staffed by a public health nurse (who is very dynamic and outspoken on the drug problem and essentially runs the clinic), an R.N., two community workers who are exaddicts and function as a liaison with the community and run groups with the patients, a psychiatric social worker, two volunteers, and one M.D. (who is usually a resident from one of the larger hospitals). The physician merely functions as a prescription writer and attends to medical problems incidental to the drug problem.

The program itself lasts for ten days. The first day, the patient is given a medical history and physical and medication. The remainder of the program, the patient participates in a group run by an exaddict (in the style of Synanon groups) and is then given his medication which consists of an anti-histamine and a mild tranquilizer. The patient population is almost exclusively made up of heroin addicts, and the return rate is poor (see page 7). The theory is to offer the addict both pharmacologic and psychological support during his withdrawal period; however, for all practical purposes, the withdrawal is accomplished on his own in the same environment that predisposes the individual to his drug abusing life style.

House of Uhuru

This is a drug program affiliated with the South Central Multipurpose Health Center on 103rd Street. It is housed in a separate facility and takes on an air of autonomy for a definite reason --- it is felt that association with an "established" government supported institution is a deterrent to the "street users" seeking of help. The majority of the staff are ex-addicts, and, as people from the community, they have the advantages of instant rapport, less reluctance on the part of the user to become associated with them, and creating an atmosphere in which "kicking the drug habit" and "making it as a person" take on a believable and attainable quality. When an addict can see that someone who came from the same place went through the same experiences and is now "clean", he is better able to identify with him.

The program is directed toward the prevention and elimination of the elements in ghetto life that predispose toward drug abuse. Uhuru provides drug education programs in the schools, holds group discussions in the evening for youngsters in the precarious age groups and adult education groups for parents. The program tried to create an alternative to "hanging on the streets," with a recreation room containing pool tables and other facilities. Job counseling and placement are provided and even temporary housing can be obtained through Uhuru. The attempt is to create a community forum, as well as a crisis intervention center that is open 24 hours a day. Complete medical and dental backing from the Multipurpose Health Center is provided, in addition to having a contract for ten beds at Harbor General Hospital for a detoxification program. Associated with this is an experimental Methadone program, where patients are given the drug for a three-day period. Following withdrawal, addicts are given the opportunity to attend group sessions several nights a week, in addition to seeing their individual counselors. If a patient presents a special problem, the counselor may refer him to a psychiatrist at the Health Center.

The program at Uhuru is extremely well planned and well rounded; however, it is difficult to evaluate its effectiveness, since it has been in existence for only several months. Their approach is based on a tremendous amount of faith in the individual and, because of this, they do not attempt to provide a drug-free environment during the critical period immediately after the addict has withdrawn physically. They feel he can and must do it on his own, and to set up an artificial environment (in the fashion of Synanon) would prevent him from using his own resources and eventually "cripple" the individual's growth.

I feel this is the addict's strengths at a time when he, in fact, needs tremendous support. The answer to this question lies ultimately with the individual user, and I feel a comprehensive program must take into account the individual differences in personality strengths and therefore provide the opportunity for a drug-free supportive environment for a limited amount of time.

Bridgeback

Bridgeback is the oldest program of its kind in the area, having been in existence for eighteen months; however, it remains the least developed in terms of actually dealing with the individual's problem. It is set up to achieve three major goals: 1) to provide a community or neighborhood oriented service to the drug abuser, 2) to provide a demonstration model for other programs in the area, and 3) to provide inservice training for counselors.

The unique feature of this program is its provision for a live-in situation, and projections for a halfway house in the future. The facility is located on Central Avenue and consists of a converted store with a living room arrangement and several smaller rooms for group discussion. There also are living quarters and kitchen facilities for twelve men, which only this past month became utilized. The program is designed for the heroin addict who has withdrawn physically but has not yet changed his life style from that of the drug culture. Also available is a hot line for crisis intervention, a drop-in arrangement at the facility open several nights a week, and now the "live-in." This is planned as a continuum or halfway house, being the last stage before he is considered to have sufficient strength to face the outside world. Bridgeback relies heavily on group techniques run by exaddicts.

A major flaw in the program is its lack of ties with a medical facility for purposes of detoxification and handling of acute overdose. This lack of coordination and communication among agencies is a characteristic of the community, and results in an inefficiency that is ill afforded in an area where so little is available. An example of where this could be implemented is for Bridgeback to set up an arrangement with the Southeast Health Clinic, which would be ideal for

two reasons. First, they are in close proximity of each other, and second, each emphasizes a different aspect of the problem -- Southeast Health Clinic, the physical withdrawal and Bridgeback, the psychological dependence and life style of the addict. Together, they would provide a complete program with a good balance of professional services and competent non-professionals.

Conclusions and Recommendations

Clearly, the problem of drug abuse has increased in Los Angeles County. Likewise, although at a lesser rate, the problem has also increased in the King-Drew service area. One can assume that the drug abuse problem here will be more difficult to overcome than it will in the County as a whole. We have pointed out that the King-Drew service area is a low-income, inner-city area. In this area where the opportunity for self-fulfillment is less, where the physical environment is less than adequate, where the general range of services offered to more affluent communities is narrower, where recreational facilities are inadequate, one can assume that a general feeling of frustration will be prevalent. We have witnessed in Vietnam what happens when people are forced to live under frustrating conditions. Many of our soldiers come home addicted to drugs. Similarly, many of the residents who live under the frustrations associated with communities like the King-Drew service area have turned to drugs.

The immediate and pressing question is, "What can be done to assist those who have become drug abusers?" We have seen that the programs

in the service area working with the drug problem are few in number. In addition, those programs which do exist are ill-equipped to combat such problems as overdoses acute toxic psychosis related to drug use.

There are tremendous difficulties related to the problem of measuring drug abuse. The standard of measurement changes from time to time and from reporting group to reporting group. Organizations which do projections on drug abuse invariably utilize police drug arrests records for their data base source. The problem here is that police departments utilize selective enforcement of the drug laws. At some intervals there is a heavy concentration on drug-abuse law enforcement, at other times there is a relaxation of the policy. Therefore, arrest statistics do not reflect an accurate picture of the drug problem.

Some organizations attempt to also use school disciplinary reports for a drug data. But frequently schools do not keep accurate reports on drug related disciplinary problems. In addition, gang problems take away time and effort which could be given to the drug problem. Clearly new programs and program approaches are needed to combat this problem.

Recommendations

- Centralization of efforts is needed in order to prevent duplication.
- Draw should assume a coordinating role for all drug related programs

in the service area. It should be made clear from the outset that Drew is not seeking to direct the efforts of the participating programs, but merely acting as a facilitator to bring the groups together to discuss material problems and to develop coordinated solutions.

- A study should be conducted which would 1) survey all agencies in Los Angeles City who are working with drug abuse problems and obtain a consensus on the definition of "drug abuse," 2) agreement should also be obtained on units of measurement for drug abuse, i.e., police arrest for specific types of drug problems, numbers of overdoses, number of confessed heroin addicts, etc.
- More emphasis should be placed on drug education within the service area. The focus here is on drug abuse prevention as opposed to working with the problem once it has developed. Traditionally, this approach is de-emphasized because one is not able to say that any future reduction in drug abuse is directly related to the educational program. But this is true of most preventive type programs in any problem area. Nevertheless, this does not negate the possibility that such programs are helpful. We would, therefore, recommend more emphasis on drug abuse education. To accomplish this goal, Drew could either give technical and/or financial assistance to existing community organizations which

are already working in the area of drug abuse education, or it could assist in the creation of new organizations which would work in this area.

- Conduct an evaluation of all drug abuse programs in the area. The evaluation should address the problems of 1) what approaches seem to be working, 2) what approaches are failing, 3) in each instance, the "why" question should be addressed, 4) research various approaches used in other communities which have been considered relatively successful, and 5) identify program gaps within the King-Drew service area.
- Set specific standards and goals for any future drug abuse program designed by Drew, e.g., to reduce drug abuse in the service area to "x" per cent of that in Los Angeles County or the National average by "y" date.

III. MATERNAL AND CHILD CARE

In order to reduce the risk of potential difficulties occurring during pregnancy, three things must happen at a minimum: 1) the woman must be aware of proper prenatal care and the signs of difficulty, 2) properly trained health personnel must be available, and 3) she must have access to medical care.

In a study conducted by the Jet Propulsion Laboratory (JPL), the following comparative statistics were developed:

Table 1

Comparison of Maternity Complications (%)

<u>Problem</u>	<u>County</u>	<u>King-Drew Service Area</u>	<u>Excess in King-Drew Service Area</u>
Complicated normal delivery	24	30	400
Complications of pregnancy	10	19	600
Complications of puerperium	2	2	0

The study further states that:

The black population in the King-Drew service area (HSA 825) appears to have a much higher incidence of complicated normal deliveries. This is in agreement with the hypothesis that the black population suffers much poorer prenatal care. The problems associated with pregnancy are among the most significant deficiencies of the health status of King Service Area...

These facts are borne out by the statistics listed in the table above and are further substantiated by the statistics in Table 2 which was adopted from the JPL report.

Table 2

<u>Parameter</u>	<u>Rate per 1,000 live births</u>		
	<u>HSA 825</u>	<u>California</u>	<u>Nation</u>
Fetal deaths (after 5 mo.) 1968			
Black	23		25.8
Nonblack	18		13.5
Neonatal deaths (0-28 days) 1968			
Black	27		23
Nonblack	13		14.7
Infant mortality (0-1 yr.) 1968			
Black	29.1	22.6	34.5
Nonblack	19	18.4	19.2
Low birth wt. (2.0 Kg) 1970			
Black	60	40	50
Nonblack	15	22	23
Out-of-wedlock births 1970			
Black	450		312
Nonblack	140		53
Maternal deaths 1968			
Black	1.54		0.69
Nonblack	0		0.19

IV. HYPERTENSION

Hypertension is not a well defined disease. Surrogates such as heart disease and high blood pressure appear to be used as operational terms. Nevertheless, a variety of undesirable health conditions are attributed to hypertension, e.g., strokes, kidney failure, heart attacks.

The JPL study states that:

The discharge data indicate that the HSA 825 [hospital service area which contains the King-Drew service area] has a lower incidence of both hypertensive and nonhypertensive heart disease than the national average. However, the death rate due to hypertension is higher for HSA 825 than the national average. We would therefore conclude that there is a high percentage of untreated cases which are not reflected in the hospital discharge statistics. This is in agreement with the national statistics showing much higher incidence of hypertension among blacks.

There appear to be some empirical studies evolving which explain the reason why the incidence of hypertension is higher among blacks than whites. Recent studies of mice under both crowded and uncrowded conditions show evidence that their condition is much more frustrated, hypertensive, and aggressive under the former conditions than under the latter.

Some social scientists have indicated that similar results occur when groups of people live in crowded undesirable conditions.* They indicate

*See Mabel A. Elliott and Francis E. Merrill, Social Disorganization, New York: Harper and Brothers, 1961

that crowded living conditions contribute to family tensions, interpersonal tensions; and in the case of the ghetto vs. the society at large, social dissonance occurs which results in both class and racial tensions (ghetto economic conditions greatly add to these tensions).

The social scientists who subscribe to these concepts believe that the "disadvantaged" often come from a family where privacy is unknown, where the family and the surrounding residents resort to immediate violence for immediate solutions to disputes and where discipline through the use of force is common. He has grown up within the value-structure of a middle-class society which holds up as a part of its culture certain goals which are alleged to be gratifying and desirable. But society has indicated that he cannot achieve these goals. For example, in his search for work -- for that one value American society holds in highest regard -- he is being measured by the standards of a society from which he has grown up in isolation. This isolation has led to his not possessing those qualities sought by employers. Because of his lack of these qualities, i.e., education, training, motivation, middle-class social values, he has been systematically screened out from many job offerings and the possibility of upward mobility.

These circumstances create a hardened bitter individual. Our social scientists tell us that the toughness, surliness, and indifference often

exhibited by the "disadvantaged" person is normally a mask worn to hide his hostility and his hurt. Interestingly enough, an executive of one large industrial corporation which gave physical exams to 1,000 disadvantaged job applicants reported that the most common ailment among these men was hypertension.*

We are told that persons from the overcrowded, deteriorating conditions of the ghetto possess an immense sense of suspicion. Odds are great that the ghetto resident possesses a police record. In the ghetto, lives are disorganized, authority resisted, and contact with the police frequent and unpleasant. Ghetto youth may have acquired a police record for the same activity that resulted in nothing more than a reprimand for a youngster from a middle class family. He grows very suspicious of decision-making in which he has played no part. Most of his life he has been bounded by decisions made by someone else, but which have had an important effect upon his own life, e.g., employment tests, welfare regulations, etc.

These frustrations, according to the social scientists of whom we have been speaking, can cause hypertension. It may be that in order to have some control over situations which affect their lives and to reduce their frustrations and hypertension, many ghetto youths turn to the organization and control exerted by gangs.

*Department of Labor, "Manpower Communication," October 1970

These are social aspects of hypertension. There remains the medical aspect of which we spoke earlier. In a memorandum dated November 3, 1972, the Hypertension Task Group, in defining the hypertension problem, stated that:

Although hard statistical data on the service area is lacking, it is estimated that the incidence of hypertension may run as high as 30% of the adult black population. The hypertension clinic is the busiest specialty clinic in Martin Luther King Hospital. The problem is further complicated by the fact that the disease is asymptomatic for the first ten years or so. Even though it can be identified early through screening, it is difficult to manage because patients tend not to continue taking medication in the early stages of the diseases when they are not experiencing symptoms of pain or discomfort. Hypertension is one of few diseases which can be kept under control and even cured in some cases if diagnosed early. Later complications of hypertension, including stroke, heart disease and kidney failure, can be avoided with early intervention and continuous treatment. In short, it is a disease which attacks a very significant number of people in the service area, and in which medical science can actually accomplish effective intervention and control with current techniques.

It would appear, then, that there are ways of managing the medical aspects of hypertension. The same may be true of the social aspects.

V. POSTGRADUATE HEALTH PROFESSIONAL TRAINING

In recent years the demand for medical and other health services has been increasing rapidly. Consumer expenditures for medical and other health care and public budgets for community health programs are at their peak. Just as any rapidly growing industry, the health industry is attracting large sums of investment capital. A significant portion of these funds is being directed toward research and technological development.

The increasing expenditures in research have led to changes in medical technology. Significant changes in technology affecting patient care facilities are of many different kinds. For example, they may be categorized in terms of: 1) developments in diagnosis and patient care, 2) hospital information handling, 3) developments affecting hospital supply and services, and 4) improvements in the management and structural design of health facilities.

Improvement in patient care technology include automated clinical laboratory equipment, artificial human organs, improved surgical techniques and the use of the electronic computer to assist in diagnosis. The latter is also being used to control the flow of information in hospitals so that physicians can get ready access to necessary data, and have their orders for treatment of patients quickly and accurately transmitted to all affected departments.

There is convincing evidence that technological advances and innovation will continue; rapid expansion of demand for health services is evident from many indications. For example, during recent years, the proportion of the gross national product spent on health care and medical care has been increasing. Including both consumer and public outlays, the proportion rose from 46 percent in 1950 to 59 percent in 1964, an increase of more than 28 percent.

Table 1
Trends in Health and Medical Care Economics,
Selected Years, 1950-64

<u>Item</u>	<u>1950</u>	<u>1955</u>	<u>1960</u>	<u>1964</u>
Total expenditures for health care: percent of gross national product	46%	47%	54%	59%
Persons with hospital expense insurance: number in millions	77	108	132	151
Percent of U.S. population	49.1%	65.2%	73.3%	79.2%*

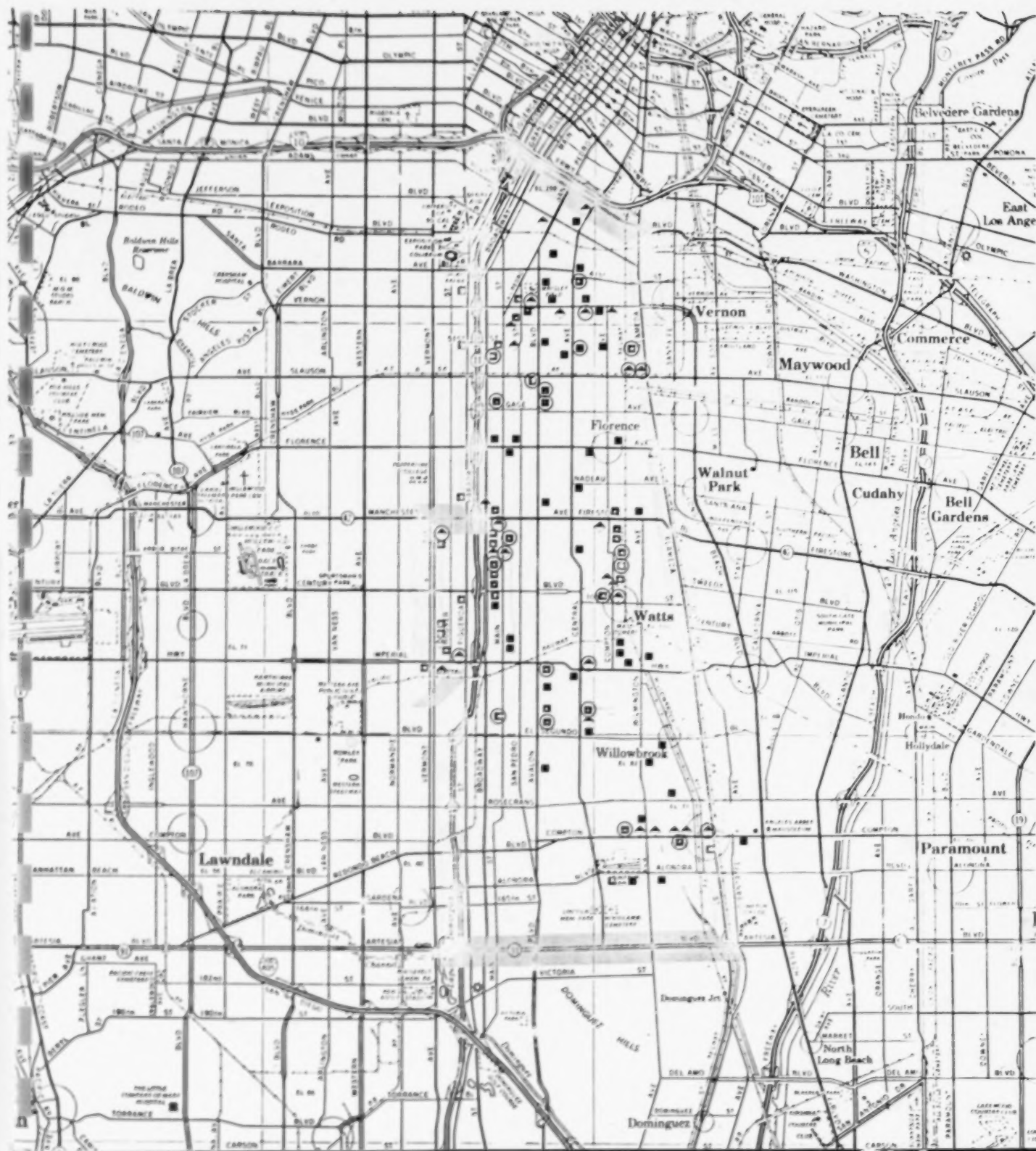
*Source: Social Security Administration

As previously indicated, this increased demand for health and medical services will increase the rate of technological advancement and innovation in the health industry. Clearly, those physicians and health professionals who expect to deliver top quality health and medical care to their clientele must have knowledge of these technological advancements and innovations.

One way to provide this information is through postgraduate training for physicians and health care professionals--by health care professionals we mean clinical psychologists, physical therapists, dieticians, pharmacists, medical technologists, registered and practical nurses, x-ray technicians, etc. Discussions with physicians in the King-Drew service area concerning postgraduate medical training revealed the following:

1. Doctors in the area do not as a rule pursue postgraduate training.
2. These doctors, consequently, do not familiarize themselves with many of the newly developed medical techniques.
3. They do not have in-depth knowledge of many recently developed medications.
4. Numbers 2 and 3 above have a negative effect on the quality of service doctors offer their patients.
5. The community's knowledge of health problems suffers because doctors cannot pass on knowledge to their clients about the latest medical treatments and medications. If community residents were knowledgeable about new treatments which could possibly correct medical deficiency possessed by them, the numbers seeking medical treatment might increase.

Some doctors felt that one of the difficulties with receiving and maintaining information on new developments in the health industry was a lack of a formal organization in the community offering postgraduate training. The institutions which are most readily available for this purpose are the University of Southern California and the University of California at Los Angeles.



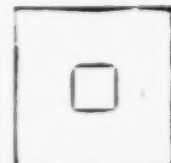
LEGEND:

- MLK-DREW SERVICE AREA
- PHYSICIANS
- DENTISTS
- 2 OR MORE PRACTITIONERS



NORTH

**GERMANILES R. DREW
POST GRADUATE MEDICAL SCHOOL
MASTER PLAN PROJECT**



**URBAN
WORKSHOP**

Doctors and other health industry professionals need the information and skills upgrading which could be provided through a postgraduate training program. The Drew School could provide a meaningful service to the physicians and health professionals in its service area as well as to the residents of the community by developing a coordinated postgraduate training program. There are enough doctors and health professionals in the service area to warrant such a program. (See the map on the following page for the location of doctors in the King-Drew service area.) In addition, the staff at the King-Drew complex could benefit from such a training program.

APPENDIX 3

Faculty and Professional Staff
Questionnaire

INTRODUCTION

This report is the culmination of a two-year effort directed toward the preparation of a Master Plan for the Charles E. Drew Postgraduate Medical School. The work was supported financially by the Commonwealth Fund and Bureau of Health Manpower Education of the National Institutes of Health (Contract NID 71-4140).

The Master Plan Study Team which prepared this report was made up of representatives of three consulting firms, retained by the Drew School under a structure of subcontracts. The firms are Lester Cataline Associates (Terra Linda, California), Arthur D. Little, Inc. (Cambridge, Massachusetts, and San Francisco), and The Urban Workshop, Inc. (Watts, California).

The overall work was divided into two phases, Phase I being of a preliminary character, particularly in regard to the definition of programs and required resources. A document entitled MASTER PLAN STUDY: PHASE I PROGRESS REPORT was submitted to the Bureau in March 1972.

The present report, then, responds to the scope of work authorized in the contract for Phase 2, and is a plan for the development of the Drew School principally in terms of internal organization, program development, estimates of required physical facilities and capital funds, and site considerations.

The work could not have been carried out successfully without the active participation of many members of the Drew faculty and staff, the administration and staff of the Martin Luther King, Jr., General Hospital, and the residents of the surrounding community of south-central Los Angeles. Names of these contributors to the study will be found in Appendix I.

FACULTY AND PROFESSIONAL STAFF QUESTIONNAIRE

Instructions

Please answer each question. For those questions which require more space than provided, use the back of the paper, indicating the number of the question you are responding to. The questionnaire should take about _____ minutes to complete. When you have finished, please place it in the envelope provided and return it to _____.

Your response will be kept confidential. You may sign the questionnaire if you desire, but your reply will still be held in confidence and not shown to any member of the Drew School or the Board.

The results of the survey will be collated by the Master Planning Consultants and fed back to the entire faculty and staff to share perceptions and attitudes more broadly and to build a base upon which to formulate goals, objectives and program priorities for the Drew School. Names will not be revealed.

To aid in the analysis of the data collected, please circle your department, position, race and number of months with Drew on the following list. Where this description would identify you individually, your response will be aggregated with others to preserve anonymity.

<u>Department/School</u>	<u>Position</u>	<u>Race</u>	<u>Number of Months with Drew</u>
Medicine	Faculty	Asian	Less than 6
Allied Health	Professional Staff	Black	6-12
Anesthesiology	Other _____	Brown	12-18
Community Medicine	Specify _____	White	18-24
Gastroenterology/Gynecology		Other	24-36
Pathology			36-48
Pediatrics		Specify _____	over 48
Psychiatry			
Radiology			
Surgery			
Administration			
(Dean's Office)			
Other _____			
Specify _____			

<u>Participation</u>
Strict full-time
Part-time

INDIVIDUAL QUESTIONNAIRE

1. Indicate by a check on the scale the point which describes how well you think Drew as an institution is responding to the needs of the King-Drew service area?

Negligibly		To the minimum extent to get by		About as well as can be expected		Actively though incompletely		Fully
------------	--	------------------------------------	--	-------------------------------------	--	------------------------------------	--	-------

Comments: _____

2. In terms of its priorities, Drew should: (check one)

Respond first to the needs of the local King-Drew Service Area bearing in mind but not being governed by the applicability of programs to a broader national constituency. _____

Respond first to the expectations of a "national constituency", bearing in mind but not being controlled by the needs of the local King-Drew service area. _____

3. Check which of these statements you think now applies to the Drew School and which one(s) should apply from this point forward:	<u>Now Applies</u>	<u>Should Apply in the Future</u>	<u>The Statement is Irrelevant</u>
Drew is a national resource; as such it should seek to attract the best possible people regardless of race or location.	_____	_____	_____
Drew's first loyalty is to its immediate service area. As such, it should recruit for all positions in the service area first. Only after exhausting the service area should it go national in its search for people.	_____	_____	_____
Drew is a minority school, for minority people, run by minority people. As such, first priority should be the hiring of minorities, mainly blacks and chicanos.	_____	_____	_____
Because Drew has a commitment to the community, technical and support personnel should be recruited from the local service area, but faculty should be recruited nationally.	_____	_____	_____

6. In terms of the health and health education problems of the King-Drew Service Area, list the six most pressing health, health related or health education needs to which Drew, as an institution, should address itself with programs. (Include, where appropriate, those needs which you believe Drew is addressing or attempting to address now.)

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

5. Indicate by a check in the appropriate column the nature of the present relationship between your department and each other department, as you perceive it.

with:	Competitive and Hostile	This Department is perfectly capable of moving in on my dept's territory; we need to stake out territorial claims to avoid conflict	Little contact; live and let live	When occasions arise, we collaborate around a specific task	Close, mutually supportive
Allied Health					
Community Medicine					
Medicine					
Ob/Gyn					
Pathology					
Pediatrics					
Psychiatry					
Radiology					
Surgery					

Anesthes.

Comments: _____

6. Now, indicate with a check in the appropriate column, what you believe the relationship should be between your department and those listed below:

with:	To avoid conflict, we should be careful to stake out territory in relation to this department	Live & let live; relatively little need or opportunity for cooperation	Several areas exist where we can cooperate more fully. We should develop these	Close, mutually supportive in numerous areas
Allied Health				
Community Medicine				
Medicine				
Ob/Gyn				
Pathology				
Pediatrics				
Psychiatry				
Radiology				
Surgery				

Anesthes.

Comments:

Areas of possible collaboration (indicate name of Department and area or specific project on which collaborative activities could be initiated or developed further):

Areas of prospective conflict (indicate name of Department and area or project in which there is a high probability of competition and conflict):

7. The concept of community control or community participation is frequently at issue when planning new programs or projects. In so far as you are aware of specific Drew programs which directly impact on the King-Drew Service area, what is Drew's posture now, in your opinion?

No community participation except as recipients of service or as trainees. Program development & implementation is a job for professionals	Community opinions entertained if volunteered	Active community participation in an advisory role to specific programs	Active community participation in decision making, but less than a majority control over the development and implementation programs	Community in a position to choose which issues and aspects of the program over which it should exert control	Community control over all aspects of the program	Don't know what Drew's posture is
--	---	---	--	--	---	-----------------------------------

Comments about specific departments, specific programs, etc.:

8. Now, indicate by a check what you believe, as a general rule, Drew's posture should be with respect to community involvement in program development.

No community participation except as recipients of service or as trainees. Program development & implementation must be left to professionals	Community opinions entertained if volunteered	Active community participation in an advisory role to specific programs	Active community participation in decision making, but less than a majority control over the development and implementation programs	Community in a position to choose which issues and aspects of the program over which it should exert control	Community control over all aspects of the program
---	---	---	--	--	---

(continued on next page)

B. (continued)

Comments:

9. What, in your opinion, should the Drew School start doing that it is not now doing?

10. In your opinion, what should the Drew School stop doing that it is presently doing?

11. Briefly describe what you feel should be the relationship between community practitioners and the Drew School.

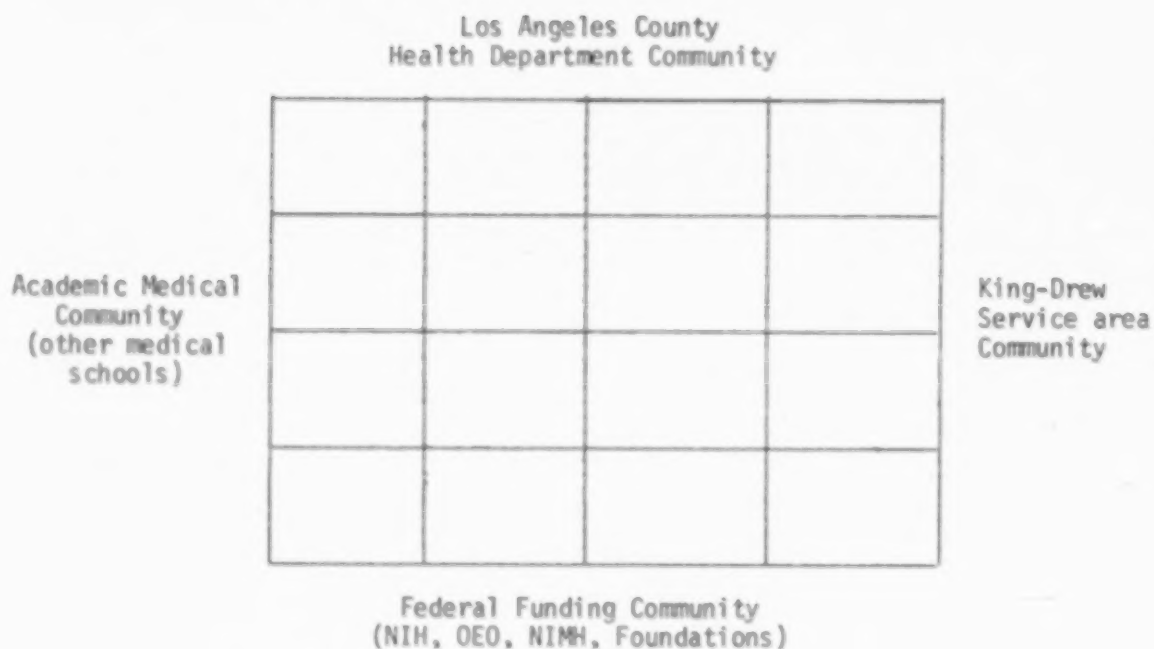
12. Please rank the following statements of the reason for Drew's existence in order of your priority: (Rank 1, 2, 3, etc.)

- a. Drew School exists to deliver health and health education services to the King-Drew Service area. _____
- b. The Drew School exists to upgrade(by training, supporting other health agencies, continuing education, etc.) the general level of health in the community. _____
- c. The Drew School exists to help the King Hospital from being "just another County facility." _____
- d. The Drew School exists to provide economic upgrading of the King-Drew Service area through jobs and training for community residents. _____
- e. The Drew School exists to provide continuing education opportunities for community physicians. _____
- f. Other (please specify): _____

13. In terms of the next 12 months, what is the most important task facing the Drew School (chose one) (Indicate with a check mark)

- a. Develop a more solid base of financial support _____
- b. Get itself together internally by developing ways of constructively dealing with conflict and working more cooperatively _____
- c. Developing and reorienting programs and services to become more relevant to the needs of the King-Drew Service area. _____
- d. Involving the community, including community practitioners, more fully in the program development activities of the Drew School _____
- e. Other (please specify) _____

14. The Drew School must respond to several "communities" at the same time. The following diagram indicates four of the most important of these communities, presently. Indicate by an "X" in the diagram where you perceive Drew is at the present time in terms of its "responsiveness" to these communities; (i.e., how actively it listens and responds to pressures from these communities).



15. Where Drew "is" may not be where you feel it should be. Indicate by an "X" on the following diagram where you feel Drew should be in terms of its "responsiveness" to its communities.

Los Angeles County
Health Department County

Academic Medical
Community
(other medical
schools)

King-Drew
Service area
Community

Federal Funding Community
(NIH, OEO, NIMH, Foundations, etc)

16. Do you believe that the Drew School should design and implement some sort of model health care delivery system for the King-Drew service area?

Yes _____

No _____ (go to question 17)

- 16a. If yes, should the effort be limited to a relatively small population group (15-30,000 people) or should it extend as rapidly as possible to the entire King-Drew service area?

limited population group _____

extend rapidly to entire service area _____

16b. What kind of system would you advocate?
Describe it and/sketch it in the space below.
or

16c. What would the implications of the model you propose be for:

1) Use of paramedical personnel _____

2) The King Hospital _____

3) Building program for Drew (centralized or dispersed facilities?)

4) The community practitioners who may operate largely in a private fee-for-service, solo setting

5) The conduct of education and training programs _____

17. Indicate in the right hand column, your perception of the role of the Dean as it is now being performed.
Rank in order of importance (1,2,3, etc.)

	Now being performed
a. Chief Executive of an organization called the Drew Postgraduate Medical School	
b. The head of the administrative operation part of the Drew School (day-to-day administration).	
c. Facilitates the development of each department (helping departmental chairmen recruit people, develop programs, obtain grants, etc.)	
d. Coordinates the development of the Drew School by pressing for interdepartmental cooperation	
e. Raises money for the School	
f. Relates the Drew School to the King-Drew Service area	
g. Protects the Faculty from the Board, and vice versa	
h. Formulates and establishes policy for the Drew School, in cooperation with the Board	
i. Serves as a mediator and problem solver among different factions and Departments in the Drew School	
j. Other (please specify)	

comments: _____

18. As a full-time member of the Drew community, indicate your feelings with respect to Drew's present line of development by making a check at the appropriate point on the scale below

Drew is moving in a direction which is opposite to my own personal goals and to the reason why I came here in the first place	Drew could move in about any direction and it wouldn't make much difference to me, so long as it stayed alive and was able to pay my salary	I'm not very aware that Drew is moving in any particular direction, but it seems O.K. to me	Drew is moving in a direction which is generally consistent with (and certainly not opposite to) my personal goals	Drew's development and my goals are all in the same direction	Drew is the most exciting place I could imagine to work. It provides me full opportunity to realize my personal goals.
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19. Indicate your position with respect to the following statements:

	Agree	Disagree
- The School of Allied Health Sciences should be as separate and as autonomous as possible from the Drew School	_____	_____
- The Dean of the Faculty of Allied Health Sciences and the Dean of the Medical School should relate as equals with respect to the Board of Drew	_____	_____
- Faculty members of the School of Allied Health Sciences should be given concurrent appointments in the Drew School	_____	_____
- The School of Allied Health Sciences should be the primary service arm of the Drew complex in terms of mounting community based training programs	_____	_____

20. What do you perceive to be the main points of conflict in the Drew School now?

21. Additional comments

APPENDIX 3

Departmental Questionnaire

DEPARTMENTAL QUESTIONNAIRE

Department Name:

1) Briefly list the specific ongoing program activities of your department:

[illegible]

2) Briefly list specific programs/projects not yet funded but for which proposals have been submitted:

[illegible]

- 3) Briefly describe the programs/projects you intend to initiate over the next 12 months, for which proposals have not yet been submitted. Give purpose, target population (if any), probable level of funding required and sources of funds, probable duration, projected staffing level, and kinds of skills needed. Indicate whether you intend to use people from other departments and from which departments they would come.

- 4) Briefly describe the strategy for developing your department over the next 12 months, including:
- a) Major sources of funds to operate your department over the next year
 - b) Funding level at present and what you anticipate 12 months hence
 - c) Types of staff training and professional development activities you intend to pursue
 - d) Objectives you intend to reach during the coming year
 - e) Areas of collaboration with other departments you intend to pursue
 - f) Type and extent of community involvement (from the Drew-King service area) you intend to develop over the next 12 months
 - g) Size you intend to be in one year

- 5) Briefly describe activities of your department not included in the program description above to round out the picture of your department:

6) Describe the types of activities in which faculty or professional staff members of your department now actively work with faculty or professional staff from other departments in the Drew School:

7) Describe the types of activities or areas in which people from your department should or could collaborate more actively with people from other departments:

8) List the names of key individuals and organizations in the King-Drew service area with which your department has active working relationships. Describe the nature of those relationships:

9) List the names of community physicians with whom you have actively collaborated to develop and implement programs:

- 10) List the names of physicians practicing in the community who are members of your department:

APPENDIX 3

Analysis of Selected Results
of the Faculty Survey

INTRODUCTION

In an effort to understand how the professional personnel of the Charles R. Drew Postgraduate Medical School viewed that institution, the Master Planning team conducted a written survey among faculty and staff of the Drew School. Two major objectives of the survey were:

- 1) to provide information to the Master Planning team as to what the general demographic characteristics of the Drew School were, what the staff perceived as the institution's major goals, how the staff viewed interdepartmental relations, what position the institution should take vis-à-vis its various communities, how the staff viewed the role of the dean, and how the institution was fulfilling the needs of individual staff members; and
- 2) the data obtained through the survey was to be fed back to the entire faculty in order that they might have a common set of information about how they, as the professional staff, viewed the institution.

The total number of faculty and staff responding to the survey was 84, out of 90 people asked to respond. The people who did respond represented essentially all of the full-time faculty and full-time professional staff of Drew on board at the time of the survey, and 40% of the part-time faculty, most of whom are local M.D.'s. Although the response rate was extremely good, especially among the full-time faculty and professional staff, the relatively small number of respondents limits the type of statistical analysis and cross tabulations which might be applied to the results.

This survey analysis is divided into the following sections: I--A Profile and General Description of the Drew Personnel Who Responded to the Survey; II--Goals of the Drew School; III--Relationship between Departments; IV--The Role of the Dean; and V--Drew's Position Regarding Its Various Communities.

SECTION I

I. Profile and General Description of Survey Respondents

This section will describe basic characteristics of respondents to the Drew staff survey. Eighty-four persons completed the questionnaire. Of this group, 52.4 percent (N=44) were full-time faculty members, 39.3 percent (N=33) were professional staff (including many part-time, locally-based physicians associated with departments in the King Hospital), and 8.3 percent (N=7) were in various other job categories such as administrative or clerical. Racially, the respondents were as follows:

Table 1

Racial Background of Respondents to the Questionnaire

	<u>Percent</u>
Asian	6.3% (N=5)
Black	65.0% (N=52)
Brown	6.3% (N=5)
White	21.2% (N=17)
Other	1.2% (N=1)

A majority of the respondents (69.9 percent) were employed full-time although there are differences in participation between racial groups (see Tables 2 and 2A).

Table 2
Race by Participation

<u>Race</u>	<u>Participation of Respondents</u>		
	<u>Full-time</u>	<u>Part-time</u>	<u>Total</u>
Black	63% (N=32)	37% (N=19)	100% (N=51)
White	88% (N=15)	12% (N=2)	100% (N=17)
Other	91% (N=10)	9% (N=1)	100% (N=11)

Table 2A
Participation by Race

	<u>Black</u>	<u>White</u>	<u>Other</u>	<u>Total</u>
Full-time	56% (N=32)	26% (N=15)	18% (N=10)	100% (N=57)
Part-time	86% (N=19)	9% (N=2)	5% (N=1)	100% (N=22)

The average length of tenure at the school was between six and twelve months. At the time of the survey, nearly 83 percent of the respondents had been at Drew for less than 18 months. Table 3 shows the distribution of respondents across departments.

Table 3

Departmental Distribution of Respondents

<u>Department</u>	<u>Percent</u>
Medicine	14.3% (N=12)
Allied Health	2.4% (N=2)
Anesthesiology	3.6% (N=3)
Community Medicine	26.2% (N=22)
Ob/Gyn	8.3% (N=7)
Pathology	6.0% (N=5)
Pediatrics	9.5% (N=8)
Psychiatry	7.1% (N=6)
Radiology	7.1% (N=6)
Surgery	11.9% (N=10)
Administration	2.4% (N=2)

Over one-quarter of the respondents (26.2 percent) were in the Department of Community Medicine. Medicine had 14.3 percent of the respondents and Surgery had 11.9 percent. Together these three departments contain over 50 percent of the respondents. There are differences between departments in terms of participation (Table 4) and racial distribution (Table 5) of respondents.

Table 4

Department by Participation

<u>Department</u>	<u>Participation</u>	
	<u>Full-time</u>	<u>Part-time</u>
Medicine	25% (N=3)	75% (N=9)
Anesthesiology	100% (N=3)	0% (N=0)
Community Medicine	81% (N=18)	19% (N=4)
Ob/Gyn	29% (N=2)	71% (N=5)
Pathology	100% (N=5)	0% (N=0)
Pediatrics	100% (N=8)	0% (N=0)
Psychiatry	100% (N=6)	0% (N=0)
Radiology	100% (N=6)	0% (N=0)
Surgery	50% (N=5)	50% (N=5)

Table 5

Department by Race - Full and Part-time

<u>Department</u>	<u>Respondents' Race</u>			
	<u>Black</u>	<u>White</u>	<u>Other</u>	<u>Total</u>
Medicine	64% (N=8)	27% (N=3)	9% (N=1)	100% (N=12)
Allied Health	100% (N=2)	0% (N=0)	0% (N=0)	100% (N=2)
Anesthesiology	33% (N=1)	67% (N=2)	0% (N=0)	100% (N=3)
Community Medicine	75% (N=17)	15% (N=3)	10% (N=2)	100% (N=22)
Ob/Gyn	86% (N=6)	0% (N=0)	14% (N=1)	100% (N=7)
Pathology	40% (N=2)	0% (N=0)	60% (N=3)	100% (N=5)
Psychiatry	83% (N=5)	0% (N=0)	17% (N=1)	100% (N=6)
Radiology	33% (N=2)	33% (N=2)	33% (N=2)	100% (N=6)
Surgery	28% (N=8)	11% (N=1)	11% (N=1)	100% (N=10)

Over 70 percent of the respondents in both Medicine and Ob/Gyn were employed part-time. Essentially, all of the respondents who indicated a part-time involvement were local physicians affiliated with one of the departments on a part-time basis. In terms of respondents' racial distribution among departments, blacks comprised the majority in six of the eleven named departments. Employment on a part-time basis might be the choice of some. However, Drew as an institution located in the black community and oriented to community needs might strive to recruit more of those persons

who are readily available from the community to fill as many full-time positions as possible.

Table 6

Respondents' Position by Race

<u>Race</u>	<u>Position Full-time</u>			
	<u>Faculty</u>	<u>Professional</u>	<u>Other</u>	<u>Total</u>
Black	59.4% (N=19)	25.0% (N=8)	15.6% (N=5)	100% (N=32)
White	80.0% (N=12)	13.3% (N=2)	6.7% (N=1)	100% (N=15)
Other	90% (N=9)	10.0% (N=1)	0% (N=0)	100% (N=10)

Table 6A

Respondents' Race by Position

<u>Position Full-time</u>	<u>Black</u>	<u>White</u>	<u>Other</u>	<u>Total</u>
Faculty	46% (N=19)	30% (N=12)	24% (N=9)	100% (N=40)
Professional	73% (N=8)	18% (N=2)	9% (N=1)	100% (N=11)
Other	83% (N=5)	17% (N=1)	0% (N=0)	100% (N=6)

SECTION II

II. Goals of the Institution

A critical aspect of any institution is the development of goals and priorities to guide its operation in providing service to its clientele. Staff members were asked a number of questions designed to elicit their opinions about what are and ought to be Drew's goals and priorities. Almost all of the respondents (98.8 percent) felt that Drew's first priority was to respond to the needs of the King-Drew service area. In light of this, their opinions about how Drew is currently performing this function are interesting (see Table 7).

Table 7

Drew Performance in Response to Service Area Needs

<u>Performing</u>	<u>Percent of Respondents</u>
Negligibly	5.3% (N=4)
To minimum extent to get by	11.8% (N=9)
About as well as can be expected	40.8% (N=31)
Actively, though incompletely	38.2% (N=29)
Fully	3.9% (N=3)

A little over 17 percent evaluated Drew's current response to service area needs negatively while another 41 percent of the respondents felt it was doing as well as can be expected. About the same proportion saw Drew responding actively to service area needs although few (3.9 percent) felt this priority was being completely met.

The orientation toward community service was assessed in terms of the importance given to various reasons for Drew's existence.

Table 8
Ranking of Reasons for Drew's Existence

<u>Reason for Drew's Existence</u>	<u>Percent Giving Each Priority Ranking</u>					<u>Total</u>
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	
Upgrade general level of health in the community	54.9% (N=39)	35.2% (N=25)	8.5% (N=6)	1.4% (N=1)	-	100% (N=71)
Deliver health and education services to community	38.6% (N=27)	32.9% (N=23)	18.6% (N=13)	4.3% (N=3)	5.7% (N=4)	100% (N=70)
Help MLK Hospital not become "just another county hospital"	4.5% (N=3)	4.5% (N=3)	15.2% (N=10)	24.2% (N=16)	45.5% (N=30)	100% (N=62)
Economic upgrading of service area via training and employment	5.6% (N=4)	9.9% (N=7)	21.1% (N=15)	40.8% (N=29)	22.5% (N=16)	100% (N=71)
Continuing education for community physicians	5.9% (N=4)	16.2% (N=11)	39.7% (N=27)	23.5% (N=16)	14.7% (N=10)	100% (N=68)

Reflected in the priorities of its staff, Drew's major reason for existence is to upgrade the general level of health in the community. As part of this process, providing health and health education services to the King-Drew service area appeared as next most important. Few see economic upgrading or helping King Hospital from being "just another county facility" as the primary reasons for Drew's existence. The majority's orientation is toward health and matters related to it.

While there is a high level of consensus regarding Drew's reasons for existence, the pattern of staff response to the question, "In terms of

the next twelve months what is the most important task facing the Drew School?", showed that other concerns were pressing also (see Table 9).

Table 9

Drew's Major Task in the Next Twelve Months

<u>Major Task</u>	<u>Percent of Respondents</u>
Involve community in program development	29.0% (N=22)
Develop programs relevant to service area needs	26.0% (N=20)
Improve internal organization and work cooperatively	24.0% (N=19)
Develop financial support	13.0% (N=10)
Other tasks	8.0% (N=6)

These tasks do not necessarily have to conflict, and, in fact, the program development effort was aimed at achieving each of the tasks listed.

Having presented the staff's view as to what Drew is and ought to be in terms of goals, priorities, and activities, this section concludes with their assessment of the institution's course as it relates to personal goals and development. Compatibility between personal and institutional goals is important for any organization, but especially for one that is new, still developing, and faced with a complex, difficult task.

Table 10

Relation Between Personal and Institutional Goals

<u>Attitude Toward Drew's Direction</u>	<u>Percent of Respondents</u>
Drew is very exciting and provides me full opportunity to realize my personal goals	8.6% (N=6)
Drew's development and my goals are all in the same direction	14.3% (N=10)
Drew's direction generally consistent with my personal goals	48.6% (N=34)
Not aware Drew going in any particular direction but seems okay to me	24.3% (N=17)
Drew could go any way as long as it survived and paid my salary	- -
Drew is moving opposite to my personal goals	4.3% (N=3)

Of importance is the indication that, at the time of the survey (Summer 1972), about one-fourth of the respondents (24.3 percent) were unaware of any organizational direction (but sensed no conflict), one indication of the need for a clearer sense of mission and purpose. 22.9 percent experienced a simultaneous fulfillment of their goals and those of the institution. The greatest number (48.6 percent) reported a general compatibility with no conflict in goals or direction between themselves and Drew. The data suggest a reasonable level of satisfaction with the general development of Drew.

SECTION III

III. Inter-departmental Relationships

The internal state of an institution can influence both the members' satisfaction in working there and the degree to which it can accomplish its purposes. This section examines staff perceptions of inter-departmental relations as they are currently and as they think they should be.

Staff members were given a list of Drew's departments and asked to indicate their department's present relationship with each other (see Table 11).

The first point regarding the data in Table 11 is that few of the staff see their department's relations with others as conflicting or competitive in any way. Allied Health and Surgery receive the most mentions in this respect. While the majority of respondents (68.2 percent) see some or extensive collaboration with Surgery, only 46.5 percent feel similarly about their relations with Allied Health and an almost equal number (45.1 percent) say the situation is one of little contact (reflecting, probably, the fact that the Allied Health effort has had a very small staff and has been engaged primarily in planning). A similar pattern exists with regard to staff perceptions of relations with the Department of Psychiatry (i.e., 47.7 percent collaborative and 50 percent little contact). Respondents perceive the remaining departments as having some to extensive collaboration with their own department, Ob/Gyn having the highest proportion of close and mutually supportive relations with other departments (43.9 percent).

Table 11

Respondent's Perception of His Department's
Current Relationship with Other Departments

Present Relationship with:	Percent Reporting Relationship as:				
	Competitive & Hostile	Encroachment; we must stake out our claim to avoid conflict	Little Contact	Some Collaboration	Close and Mutually Supportive
Allied Health	8.5% (N=6)	-	45.1% (N=32)	33.8% (N=24)	12.7% (N=9)
Community Medicine	1.6% (N=1)	1.6% (N=1)	38.1% (N=24)	28.6% (N=15)	30.2% (N=19)
Medicine	-	-	24.6% (N=13)	39.3% (N=24)	36.1% (N=22)
Ob/Gyn	-	-	24.2% (N=16)	31.8% (N=21)	43.9% (N=29)
Pathology	-	-	28.6% (N=18)	39.7% (N=25)	31.7% (N=20)
Pediatrics	3.1% (N=2)	3.1% (N=2)	15.6% (N=10)	40.6% (N=26)	37.5% (N=24)
Psychiatry	-	-	40.9% (N=27)	40.9% (N=27)	18.2% (N=12)
Radiology	-	-	36.5% (N=23)	24.9% (N=22)	28.6% (N=18)
Surgery	7.6% (N=5)	3.0% (N=2)	21.2% (N=14)	31.8% (N=21)	36.4% (N=24)
Anesthesiology	2.3% (N=1)	-	50.0% (N=22)	31.8% (N=14)	15.9% (N=7)

In completing the description of Drew's internal relations, staff were asked what they thought their department's relations with each other department should be (see Table 12).

The data in Table 12 are most interesting in comparison to Table 11. Overall, most staff members feel relationships should be more collaborative than they are at present. There is still some doubt remaining regarding Allied Health. 5.6 percent of the respondents say they must stake out their department's relation to Allied Health or that there is little need or opportunity to cooperate. Community Medicine, Pediatrics, Anesthesiology, Pathology, and Psychiatry are cited by some as departments with which need for collaboration is relatively low.

Part of this may be due to the fact that a high collaboration is not required between some departments, particularly those that are highly specialized with, traditionally, few areas of overlapping responsibility.

This explanation does not fit the case of Allied Health where the situation is complicated because of problems which have been encountered in establishing that arm of Drew. The School of Allied Health was appended to Drew, in part, as a result of community concern (and concomitant pressure) that the institution provide training and employment opportunities for residents. At the time of the survey, Allied Health had its own dean who reported to the Board along with the Medical School dean.

Table 12

Respondent's Opinion About What His Department's
Relationship with Other Departments Should Be

<u>What the Relationship Should be with:</u>	<u>Stake Out Our Territory to Avoid Conflict</u>	<u>Little Need or Opportunity for Cooperation</u>	<u>Develop Those Areas in Which We Can Cooperate</u>	<u>Close and Mutually Supportive in Numerous Areas</u>
Allied Health	4.2% (N=3)	1.4% (N=1)	40.8% (N=29)	53.5% (N=38)
Community Medicine	1.5% (N=1)	4.5% (N=3)	33.3% (N=22)	60.6% (N=40)
Medicine	-	1.5% (N=1)	27.9% (N=19)	70.6% (N=48)
Ob/Gyn	-	2.9% (N=2)	27.1% (N=19)	70.0% (N=49)
Pathology	-	11.8% (N=8)	27.9% (N=19)	60.3% (N=41)
Pediatrics	2.9% (N=2)	4.4% (N=3)	20.6% (N=14)	72.1% (N=49)
Psychiatry	1.5% (N=1)	12.3% (N=8)	20.0% (N=13)	66.2% (N=43)
Radiology	-	9.0% (N=6)	31.3% (N=21)	59.7% (N=40)
Surgery	-	4.5% (N=3)	25.4% (N=17)	70.1% (N=47)
Anesthesiology	-	15.8% (N=6)	31.6% (N=12)	52.6% (N=20)

Allied Health's primary task was to be to recruit and train residents for various paramedical positions (physicians' assistants, x-ray technicians, etc.). This department was not the traditional academic department one would find in a medical school and this may partially explain mentions of isolation or conflict directed toward it by staff in other departments. It is also possible that the existence of Allied Health was viewed as potentially limiting the capacity of specialized departments to develop their own paramedical (or other community-oriented) programs. As long as one department was designed for this purpose and if it received the necessary resources and administrative support, it might reduce the claim others might put on these resources.

SECTION IV

IV. The Role of the Dean

As the head of the Drew School and its most visible representative in the eyes of the community, the Dean's role is a pivotal one. Staff members were asked to rank various aspects of the Dean's role as they now perceive it is being performed (see Table 13).

Table 13

Respondents' Ranking of Aspects of Dean's Role as Now Being Performed

<u>Role as now performed:</u>	<u>Percent Giving Each Rank</u>						
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>
Chief executive of Drew	70.0% (N=35)	10.0% (N=5)	8.0% (N=4)	2.0% (N=1)	8.0% (N=4)	2.0% (N=1)	-
Day-to-day administration	11.4% (N=5)	34.1% (N=15)	18.2% (N=8)	11.4% (N=5)	6.8% (N=3)	9.1% (N=4)	9.1% (N=4)
Facilitates each department's development	23.3% (N=10)	27.9% (N=12)	16.3% (N=7)	16.3% (N=7)	2.3% (N=1)	11.6% (N=5)	2.3% (N=1)
Coordinates Drew's development by pressing for inter-department cooperation	3.0% (N=1)	12.1% (N=4)	18.2% (N=6)	27.3% (N=9)	21.2% (N=7)	9.1% (N=3)	9.1% (N=3)
Raises money for Drew	2.9% (N=1)	5.7% (N=2)	31.4% (N=11)	22.9% (N=8)	14.3% (N=5)	14.3% (N=5)	8.6% (N=3)
Relates Drew to King- Drew service area	-	2.8% (N=1)	8.3% (N=3)	16.7% (N=6)	30.6% (N=11)	22.2% (N=8)	19.4% (N=7)
Protects faculty from Board and vice versa	-	-	5.9% (N=1)	23.5% (N=4)	17.6% (N=3)	17.6% (N=3)	35.3% (N=6)
Formulates Drew's policies	11.5% (N=5)	27.9% (N=12)	23.3% (N=10)	9.3% (N=4)	11.6% (N=5)	4.7% (N=2)	11.6% (N=5)
Mediator and problem solver	4.8% (N=1)	14.3% (N=3)	9.5% (N=2)	14.3% (N=3)	4.8% (N=1)	28.6% (N=6)	23.8% (N=5)

There is a high level of agreement (70 percent) among the staff that acting as the Chief Executive of the Drew Postgraduate Medical School ranks highest among all aspects of the Dean's role as currently performed. The next most visible aspects are his work in day-to-day administration, facilitating departmental development, and formulating Drew policies. He is least viewed as a mediator among different factions or departments at Drew.

His role as someone who relates Drew to the King-Drew service area is also accorded low priority in terms of perceptions of his present role. The data indicate a strong tendency to view the Dean as primarily concerned with administrative and operational matters within Drew.

While there is strong pressure for the Dean to respond to the service area by various constituencies, the staff does not see this as one of his major current roles.

SECTION V

V. Drew's Relationship to the Community

Drew is an institution located in a minority community, part of whose mission is to serve that community. An important aspect of such service concerns the relationship between community needs and program development. At issue is the degree to which institutional plans and programs are subject to the influence of community residents upon whom they will have an impact. Staff members were asked to indicate the current posture at Drew regarding residents' involvement in community-related programs (see Table 14).

Table 14

Current Nature of Community Participation in Drew Program Development

<u>Current Posture Regarding Community Involvement in Drew Programs and Projects</u>	<u>Percent Mentioning</u>
No community participation	1.3% (N=1)
Community opinions considered if volunteered	6.6% (N=5)
Participation in advisory role to specific programs	27.6% (N=21)
Participation in decision-making but less than majority control over program development	14.5% (N=11)
Community can choose which program aspects they want to control	13.2% (N=10)
Community control over all program aspects	1.3% (N=1)
Don't know what Drew's posture is	35.5% (N=27)

Only 8 percent see the current situation as essentially nonparticipative while another 27.6 percent see residents acting in advisory capacities to a few specific programs. Just over 14 percent view the current relationship as participative with the community having less than majority control over program decision-making. The same proportion (14.5 percent) believe there is effective community control over Drew's planning and programs.

Perhaps of most interest is the fact that 35.5 percent of the staff cannot identify any specific Drew posture toward community involvement in its program activities.

As an indication of possible changes in the future, staff were asked what Drew's posture should be regarding community participation in planning and programming (see Table 15).

A pattern of joint decision-making with the community having less than majority control is the form of participation favored by 47.3 percent of the staff. About 27 percent believe that a situation of more effective control in which the community can select and control (and veto) program aspects should be the norm at Drew. Finally, about 30 percent still support essentially nonparticipative forms of interaction with the community.

Table 15

What Nature of Community Participation in
Drew Program Development Should Be

<u>What Drew's Posture Should Be Regarding Community Involvement in Program Development</u>	<u>Percent Mentioning</u>
No participation	1.3% (N=1)
Community opinions considered if volunteered	2.6% (N=2)
Participation in advisory role to specific programs	26.9% (N=21)
Participation in decision-making but less than majority control over program development	42.3% (N=33)
Community in position to choose which program aspect they want to control	21.8% (N=17)
Community control over all program aspects	5.1% (N=4)

Comparing Tables 14 and 15 reveals that the staff generally favors a greater degree of community participation in program development than was perceived to exist in the summer of 1972. The median assessment of the present degree of community participation indicated "participation in an advisory role to specific programs." The median assessment of what community participation should be was "participation in decision-making, but less than majority control over program development."

APPENDIX 3

Feedback Report No. 1

(Faculty Survey)

September 7, 1972

To: Drew Faculty and Staff

From: Master Plan Study Consultants

Subject: Feedback Report No. 1; Partial results of questionnaire administered during August, 1972

Question No. 4

"In terms of the health and health education problems of the King-Drew service area, list the six most pressing health, health-related, or health education needs to which Drew, as an institution, should address itself with programs..."

(Note: Eighty-six completed questionnaires were returned, including 54 full-time faculty and professional staff, 25 part-time professional staff (mainly physicians in practice in the service area), and 7 support staff.)

The questionnaire results for question number four have been categorized and are listed here in order of frequency of mention.

<u>Needs of the Service Area</u>	<u>Number of Mentions</u>			<u>Total</u>
	<u>Faculty & Professional Staff</u>		<u>Supporting Staff</u>	
	<u>Full Time</u>	<u>Part Time</u>		
1. Basic health education for residents of the service area	27	11		38
2. Health professions training for residents of the service area, especially allied health	25	7		32
3. Pre-natal, maternal and child care	19	6	1	26
4. Drug abuse	14	4	1	19

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 From: M.P.S. Consultants
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<u>Needs of the Service Area</u>	<u>Number of Mentions</u>			
	<u>Faculty & Professional Staff</u>		<u>Supporting Staff</u>	<u>Total</u>
	<u>Full Time</u>	<u>Part Time</u>		
5. Development of a health care system for the service area	14	4		18
6. Sickle Cell and other hereditary diseases of particular concern to the service area	13	3	2	18
7. Continuing education for community physicians	8	7		15
8. Nutrition/reduction of obesity	9	4	2	15
9. Hypertension and related problems	11	3		14
10. V.D.	10	1	1	12
11. Basic economic development	6	4		10
12. Mental health	6	2	2	10
13. Trauma/emergency services	9			9

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<u>Needs of the Service Area</u>	<u>Number of Mentions</u>			
	<u>Faculty & Professional Staff</u>		<u>Supporting Staff</u>	<u>Total</u>
	<u>Full Time</u>	<u>Part Time</u>		
14. Family planning	5	2	2	9
15. Environmental hazards (accidents, dog bites, lead poisoning, etc.)	5	1		6
16. Other:				
Adolescent problems)				
Problems of the aged)				
Cancer)	3 (av.)	1 (av.)		4
Diabetes)				
Dental care)				
School health problems)				

APPENDIX 3

Feedback Report No. 2

(Faculty Survey)

September 8, 1972

To: Drew Faculty and Staff

From: Master Plan Study Consultants

Subject: Feedback Report No. 2; Partial results of questionnaire
administered during August, 1972; Questions 9 and 10

Question No. 9: "What, in your opinion, should the Drew School start doing that it is not now doing?"

A. Full-Time Faculty and Professional Staff

- (1) * "Defining community."
 - * "Contacting the community at large and dealing with representatives from all areas of the community as a unit, i.e. Elks, Eastern Star, NAACP, Urban League, ministerial associations, medical society, bar, social clubs, senior citizens, adolescent club groups."
 - * "Cease dealing with individuals or fragmented community groups who claim to represent the community at large and may be interested only in their remunerative efforts."
- (2) * "Begin intensive discussions and plans for comprehensive, cohesive, integrated system of primary health care."
 - * "Consider inter-departmental approach to continuing education for community physicians."
 - * "Develop library and 'learning center' resources."
 - * "Define major priorities and develop inter-departmental approach to same."
 - * "Developing consolidated biomedical research base."

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- (3) • "Develop health care network models and test them in terms of:
 - 1. Meeting health needs of consumers effectively in manner that is acceptable to them and to physicians.
 - 2. Their cost efficiency.
 - 3. Their post-graduate medical education effectiveness.
 - 4. General applicability to future needs of health care systems organization."
- "Develop a broad base of support in community via organizations such as schools, churches, fraternal groups."
- "Organize existent health care resources in community with a common framework."
- (4) • "Develop a wider, closer and better relation with community physicians.
 - "Develop direct teaching programs. Too much verbiage at present with too little teaching."
 - "Plan and rapidly implement new teaching programs and facilities."
- (5) • "Immediately develop an associate degree program (A.A.) leading to the RN and preceded by preparation for high school equivalency certificate."
 - "Deliver maximum service to King-Drew population."
- (6) • "Not being familiar with what the Drew School is now doing in relation to community programs, I have no basis for rendering an opinion."
- (7) • "More entrance into the community such as more frequent church and school programs, both to educate and be educated about health and health related problems. Also, more effort to recruit reliable community representation and involvement. In general, work toward better communications with the community."

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- (8) * "From where I sit, I do not really know what Drew is doing in the community."
- (9) * "A monthly newsletter for faculty and the same or a second one for the community."
- (10) * "Keep the faculty aware of its many programs via a weekly or biweekly newsletter."
- (11) * "Enlarge significantly its breadth of community representation in all aspects of the program."
- (12) * "Not informed enough to give an opinion."
- (13) * "Design a cohesive system of health services involving all departments in mutual planning and implementation to meet existential health realities. This should include cooperative interdepartmental studies in cases where needs are not clearly identified or innovative approaches are necessary."
- * "Stop talking in abstractions and start goal directed planning, search for funds and personnel and provision of services."
- (14) * "Adopt a firm and clear stand about what it feels the role of community should be in relation to the school and vice-versa. Define whether or not "Master Planning Study" means a study to plan for the future and recommend - taking into account the goal and objective for which the school was designed or whether part of its charge is to add to or make criticisms - somehow our frame of reference should be clear - that would be a start."
- (15) * "Interdepartmental meetings at levels other than chairmen."

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- (16) • "Establish an office through which the special concerns of the Spanish surname population of area can be met on the highest level so as to eliminate TOKENISM. Chicanos must create and implement our own project components."
- (17) • "Work on becoming more cohesive with the Martin L. King Hospital staff."
- (18) • "I need more input about the role of the Drew School."
- (19) • "Develop a strategy and approach to achieve involvement and participation from broader segments of the hospital service area."
- (20) • "Community organization activities should be more broadly dispersed to arouse the health concerns and interests of groups of all types in all geographic neighborhoods of the King-Drew service area."
 - "Concentrate on staffing hospital so that full hospital services can be realized by the community. Although training and research activities are primary reasons for the school's existence, I feel that emphasis should be given to service at this stage of the school's development.
 - "In-service training (staff development) to provide opportunities to staff for promotion, etc. Special emphasis should be given to increasing the vocational potentials of employees from the community. Policies permitting persons time off to pursue educational courses is a step in this desired direction."
- (21) • "The Drew School should establish a community base in order to identify what the community perceives to be its problems."
- (22) • "Eliminate white control of key positions."

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- (23) • "Become more active in promoting and expanding school of Allied Health Services."
- (24) • "Get community health going."
- (25) • "More in depth community research - have more qualified researchers to handle task."
- (26) • "(1) Each person should personally go out into the community, meet people and listen to them. (2) Have Drew School member attend community organization meetings if it can be arranged."
- (27) • "Begin by developing an overall plan for the coordination of health services to this community and address the problems of how these tie into a fabric of a society. This burden must fall on the Department of Community Medicine. Original thinking must begin and endless evaluation of past programs must not end but be slowed down and fit into an overall perspective."
 - "The School of Allied Health must become active under a competent individual. This is the only hope if "Drew" is to really make an impact in education in this area."
- (28) • "More emphasis and direction to faculty re: our responsibility to the community - certain minimums."
 - "Greater departmental involvement with actual community participants."
 - "Greater publicity re: this involvement - Drew newsletter to community groups, etc."
- (29) • "Produce and circulate newsletter to faculty."
 - Circulate meeting notes (accepted by total faculty) on items committees have under discussion, decisions reached, projects in operation, projects being contemplated, etc."

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- "Legitimize orientation procedures for each new personnel via:
 - a. brochure explaining opportunities and benefits, policies
 - b. tenure and promotion procedures
 - c. giving background (historical view) of Drew and relationship
i.e. King, USC, UCLA
 - d. provide faculty with a directory
 - e. provide faculty with progress reports, etc.
 - f. continuing community education process."

(30) • "Integration of program planning."

- "Some affiliation with political base."
- "DEVELOP PR Program. Need public affairs office."
- "Coordinate program development activities in hospital."
- "Looking for help for controller."

(31) • "Begin to institute (create) a program of total health care that is comprehensive and accessible to all persons in the community. This system should be some type of health network that incorporates all health care facilities and practitioners from the community. Success here will or may determine future steps."

B. Part-Time Professional Staff (Mainly M.D.'s)

- (1) • "Develop strategy for involving community residents at all levels of planning and implementation - in all programs of the school."

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- (2) * "It should get a broader representation from the community to participate in its programs."
- * "It should not allow its programs to be dictated or controlled by a small self-interest group who claim to represent the total community."
- (3) * "Developing methods to teach and train people to become physicians, dentists, etc. to practice in the community."
- (4) * "No dissenting opinion - very much satisfied with plan the Drew School has used."
- (5) * "Involvement of general practice physicians in entire program, if possible."
- * "Community health education programs."
- (6) * "The school is doing a satisfactory job."
- (7) * "Fire the firm that drew up this slanted, terribly biased questionnaire!!! An assumption has been made by the supposedly 'objective consulting' firm that turmoil, conflict and other negative interactions occur in the school. No allowances or assumptions were made on the positive roles and activities the school has participated in. Thusly, objectivity is a nebulous, amorphous entity in this questionnaire but the firm was paid to objectively assist us in our planning. Since they are not doing what we paid for--TERMINATION OF THE CONTRACT!"
- (8) * "Drew should start doing at least two things to improve its potential for survival--anywhere. To improve its fiscal survival and potential influence, Drew had best garner more \$\$\$ which are free of county constraints. I do not believe the faculty will be sustained indefinitely by the ponderous county administrative structure or

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lack of supporting services related to education and community development. Drew has to define its area of expertise and, working within that, do better and more quickly such things as assessing the capacity of the providers to organize a health service system, to educate sizable numbers of employable health workers, and to work with corporations and other interests to upgrade the environment and potential of the community to be productive."

- "Drew should be seen in the community--a speaker's bureau to dispense faculty and staff regularly to churches, meetings, schools, coupled with mechanisms and programs to draw people here to see what stuff the School is really made of--is essential. I disagree profoundly with the analysis of one consultant that the major health problems in the community are venereal disease and obesity and other manifestations of poverty and injustice. The major problems around health in this community, in my view, are the lack of adequate health manpower and facilities in accessible, coordinated settings. The potential for treating VD and obesity is far greater with organization and leadership and skilled health management--the qualities Drew and King were originally created to positively influence. Drew could take on one tangible program--such as obesity control--that can have an impact on the economy, employability, and the health of future generations. But I perceive that as a project--which could be done in the community, not in the hospital setting, and perhaps worth trying. But I don't think Drew should have spent its RMP dollars on an obesity control program--deferring indefinitely acquiring the information and tools to help the community organize itself around health."
- (9) • "Start listening attentively to a community that has long "lived" its health and related deficiencies! This, both to allow community to "let off steam" and to learn from exchanges with community that breadth and depth of the frustrations it has known, so that Drew's program efforts may more closely mesh with community aspirations and hopes.
- "Be aware of new trends in health-care delivery geared to total community concerns and insure that its total program addresses those ultimate concerns. No longer can any program in medicine achieve maximum success if it is related solely to "professional" interests and techniques."

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C. Support Staff

- (1) * "Making community aware of existing services and helping them to develop and coordinate programs and projects to improve existing services."
- (2) * "I feel there are a lot of things the Drew School is doing and will continue to do. It's a new institution and time will have to be taken in order to implement all future programs. I feel there is nothing Drew can start doing more of than it so far has and is doing."
- (3) * "Structure for 'real' (whatever that is) community input. Find out: a) What is a 'real' community, and b) Tap it."
- * "Underline its philosophy with operational commitments to improve the economic profile of the community in whatever ways it can."
- * "Avoid the good health care affluence syndrome (I take that back, it is doing that now I believe)."
- * "Recognize and/or structure for needs of staff; i.e. emotional; interaction conflicts; workload; social. There is a strong aura of "zeal" which is sometimes felt as an imposition because there is very little recognition (except negatively) to human limits of staff members. There is a very real continuing over-commitment of work load on staff, probably due to the setting and needs of community and role of Drew. This will most likely increase and I think some recognition of staff individual limits would be constructive. I find the steady begging for money from staff's pockets - atrocious - particularly as Drew evidently makes no budgetary allowances for staff well-being. Example: No coffee provided; No travel allowance; Drew picnic should be free."

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Question No. 10: "In your opinion, what should Drew stop doing that it is presently doing?"

A. Full-Time Faculty and Professional Staff

- (1) * "Wasting time".
- (2) * "Generating so much verbiage and paper".
- (3) * "Still too much parochialism in programs of in-house nature, plans for research and post doctoral training programs. Still too exclusive with respect to involving professionals from allied health fields other than medicine".
- (4) * "Nothing".
- (5) * "It should stop isolating itself from the community and over reacting to problems with some people in the community".
- (6) * "Nothing".
- (7) * "Playing a "quiet" and perhaps "passive" role".
- (8) * "Should stop being more responsive to political pressures than to self-determined development".
- (9) * "I feel the school should discard as many negative trappings of bureaucratic organization as possible and still function as an efficient operating agency. I must emphasize that rapid response to community demands, problems and needs must be built into the school's mode of operation. High consideration must be given to effecting communication technique and methods that will facilitate inter-department functioning and community/school relationships. The school has to reach out aggressively to all factions in the community. The youth program of DCM is a positive example of the school's outreach program".
- (10) * "Waiting for MLK to feel a part of the total picture".
- (11) * "Stop treating Chicanos as an insignificant entity that the school has to respond to only on a token basis".
- (12) * "Allow other than administration of school to attempt to dictate school policy".

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- (13) * "Stop compromising with individual community persons over personal issues.
* "Stop emphasizing town-gown conflicts".
- (14) * "Am not very clear what Drew School is doing".
- (15) * "Stop trying to dictate individual departmental policy".
- (16) * "The Drew School should stop bounding to the Yo-Yo of a militant few with highly personalized vested interest speaking for the community, but in fact, representing a very small faction of the community".
- (17) * "Creating untoward public issue through its inappropriate methods of working co-laborately with its service community constituents".

B. Part-time Professional Staff (Mainly M.D.'s)

- (1) * "Bending over backwards to please one faction in the community. This faction should be heard from but not to the degree it is now heard from. Other organizations, "Community leaders" and residents should be allowed equal time for equal input".
- (2) * "Do not agree to contracts with cooperating medical schools at this stage that would develop MLK as a satellite rather than a viable self sustaining training center once all programs are fully established".
- (3) * "Creating a poor public relations image by ineffectual projection of goals to community: Aims may be high but what is transmitted to community in many instances is suspicion".
- (4) * "I am not aware of any specific program or activity which I would want to stop".
- (5) * "Put an immediate end to internal divisions, whatever their nature and causes! Even where honest differences of opinion may arise within the school's personnel, inevitable when numbers of people are working on common problems, those differences should be resolved amicably and on the basis of a consensus. They should never be allowed to produce a dichotomy in the institution's public image, approach to problems, and procedures toward ultimate goals".

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- (6) * "I don't know enough about what they are doing".
- (7) * "Drew should also actively try to influence the quality of medical administration in King Hospital, until such time that King Hospital is not the major domain for Drew activities. Some people will say that Drew should stop recruiting any persons who are not members of minority races. If the philosophy now is that survival in this community requires the institution to be all-black and brown, then the powers at Drew (Board and Administration) should consider the capacity of the School to attract \$, to survive as an educational force regionally and nationally, and to exist at all. Maybe LA County is ready to contract with part-time community physicians for medical services in public hospitals-I personally don't believe so, and the County would sooner turn the Hospital over to USC or UCLA".

C. Support Staff

- (1) * "Drew School should concentrate mainly on the health and welfare of the community, along with the community; instead of a million other programs first".

APPENDIX 3

Feedback Report No. 3

(Faculty Survey)

TO: Drew Faculty & Staff

FROM: Master Plan Study Consultants

SUBJ: Feedback Report #3. Partial results of Questionnaire administered during August, 1972; Question 11.

Question No. 11: "Briefly describe what you feel should be the relationship between community practitioners and the Drew School?"

A. Full-Time Faculty and Professional Staff

- (1) "Community practitioners should be receiving benefits of the Drew School's continuing education and at the same time should be actively supporting school via attending staff association, faculty & committee appointees. These physicians should be as much to the Drew as full time faculty physicians".
- (2) "Mutual cooperative efforts reflecting education, teaching, service and medical research."
"Assist in improving social economic conditions in the King-Drew service area".
- (3) "Close, cordial and coordinated effort in the areas of mutual learning and delivery of health care services".
- (4) "Must be invited to join the clinical attending staff if certain standards are met. It should be a privilege to be a member of the school, but the school should make available post-graduate training courses, successful completion which would qualify a physician for a school appointment".
- (5) "They should have Drew appointments commensurate with the level of their activities in the King Hospital".
- (6) "They should be a very close relationship. The community practitioners should be made to feel that a failure for the Drew School is also a failure for them".
- (7) "The Drew School should establish a warm close relationship with the community practitioners. It should serve as an educational center to which the practitioners could come to learn the current and up-to-date developments in medicine and health care. Additionally, Drew School should provide the medium in which the various community practitioners could organize to better serve the community. In this regard, Drew should encourage participation of practitioners in teaching and other related service to help realize the goals of educating medical and paramedical personnel as well as upgrading the overall quality of community health care".

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- (8) * "Participation when ever they are in need of it."
* "To be involved in more activities".
- (9) * "Intimate; they should be an integral part of the Drew School. If qualified, they should be sought as teachers, if not they should be encouraged to continue their education for the community's sake".
- (10) * "The Drew School should be a friendly resource actively inviting the community practitioners to utilize the facilities of Drew for advancement in his field".
- (11) * "Community practitioners should be actively encouraged to take part in Drew programs, treat patients at MLK, and admit their own patients to MLK on any fee basis mutually acceptable".
- (12) * "Symbiotic".
- (13) * "Must be meaningfully integrated".
- (14) * "Coequals in titles, privileges, respect. Mutual support in enterprises for the people of the community, the sick and the disheartened".
- (15) * "To the extent possible, the community practitioners should be drawn into the affairs of the school, should be faculty members and collaborators in development of the health care network models".
- (16) * "Should be a close working relationship. Both are in the business of providing services to the same population. Need to exchange, share information, avoid duplication especially in research. COMPETITION should at all times be avoided".
- (17) * "The school should be the resource by which individual practitioners may improve their practice and their skills".
- (18) * "Community practitioners should be eligible for clinical faculty appointments to the school."
* In the case of Medex, preceptors should receive clinical faculty appointments.
- (19) * "Drew should seek to offer services to the practitioners as they indicate their need & desire for such. Drew should accommodate them in every manner possible in order to strengthen these doctors' capacity to deliver or render quality medical care. Drew should also attempt to be innovative and in sentinel fashion initiate the development of a community medicine curriculum which is annual, local, convenient, and accessible for local

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physicians. Special, current problems - medi-socio - economic should be kept up to date as an info bank".

- (20) * "There is minimal meaningful contact or communication between the Drew School and the community practitioners. In my opinion the majority of the community practitioners look upon the School as a threat to their involvement and control of the King Hospital".
- (21) * "Drew should be a "big brother" for community practitioners, in moral support and care. It also should be a center of knowledge exchange".
- (22) * "Close and mutual".
- (23) * "Postgraduate courses; volunteer time to clinics; supervision of trainees; on attending staff; advisory to Drew as to needs of the community practitioners".
- (24) * "Harmonious. The practitioners should feel the King is their hospital and the Drew staff is here to help them. The school should serve as the vehicle for postgraduate education of the community physicians".
- (25) * "Ideally the community practitioners should become involved in the process of teaching and getting taught. This can only be done if the physicians begin to use the hospital actively, follow their own patients and have real interaction over both scientific and social problems regarding a patient. The admission of a patient without any real follow-up in the hospital by the physician is of little value and unjustified".
- (26) * "Each has a responsibility to make the Drew School work - for the community - not for individual gains! Working should be constant between small committee-board, Drew School, Drew Society - to determine better solutions to current problems of relating".
- (27) * "Both realize mutual advantage as they develop programs to provide pt. service for the area and postgrad. ed. programs".
- (28) * "Mutual cooperation with closer relationship by means of active participation".

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- (29) * (1) Use of facilities with community practitioners
- (2) Use of workshops, conferences etc. on new modes of practice
- (3) In-service & formal education programs for specialities
- (4) Programs spun-off of valid research for black (minority community)
- (5) Encourage non-faculty members to write articles, engage or participate in research projects
- (6) Be avante garde in medical outlook - i.e. having a view that is beyond the here & now toward what might/should/must be."
- (30) * "CLOSE - advisory & participation & education".
- (31) * "Cooperative & supportive".

B. Part-time Professional Staff (Mainly M.D.'s)

- (1) * "Should be involved in program planning and implementation of service programs. Should become integral part of the planning process for programs of continuing education".
- (2) * "Drew is a postgraduate medical school. Therefore, practitioners from the community should have a positive relationship with them. They should support each other in the various programs sponsored in the community. In short, they should play a supportive role to each other".
- (3) * "1) Cooperative and mutually informative.
2) Educational (continuous).
- (4) * "Encourage more part-time (paid) faculty appointments to the Drew School. In my opinion, this will help establish and motivate a closer relationship".
- (5) * "The Drew School should serve as a resource which would provide support for the local practitioners in terms of continuing education, information and advice relating to specific problems and should also serve as a forum where ideas and attitudes could be expressed and interchanged".
- (6) * "Mutual support and respect".
* "School should go to practitioner - not only invite.
- (7) * "Feel that community practitioners should be involved on some tangible basis with the school. At this time I have no actual suggestion as to how practically the relationship should be worked out, but the community doctor should have some real role and responsible involvement with the school. His support should be actively sought".

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- (8) * "Post graduate training geared to the practicing M.D."
- (9) * "Drew School should provide continuing education opportunity for the community physician".
 - * "There should be mutual cooperation in resolving health problems in the community".
- (10) * "Should be involved in the school. The school should actively encourage participation of local practitioners".
- (11) * "Close".
- (12) * "A part of the team and available to help where needed".
- (13) * "They must be a mutually supporting relationship between the school and practitioner to be a successful undertaking".
- (14) * "Supportive - act as a resource in medical and health field. To encourage community based health programs and give assistance when possible".
- (15) * "First, let's recognize there are at least 2 kinds of community practitioners. There are the overworked practitioners who function in the Crenshaw-Santa Barbara area, some of whom have patients from the HSA but who live mainly from clientele in that neighborhood--middle class and upper-class black patients. I believe we should concentrate initially on assisting the MD's in the immediate community as much as we can--supplying assistant manpower, organizational know-how, continuing education in forms that are pertinent, and, by so doing, attract others to seek practice in the community and to be on staff at the hospital. To the extent that Drew-King, a public institution, can encourage camp #2 from proprietary interests, to meeting the needs of a poorer community, we will be remarkable. There is so much "medical business" in the broader community that Drew and King may not be able to entice or serve Camp #2 by the same modes. They probably don't feel enormous responsibility for caring for the poor; they do enjoy privileges and some are probably working very hard in King now, feeling comfortable in the teaching setting. But, King is not for all of them--and we should concentrate our efforts on meeting the educational and service needs of the MD's and other health workers in the service area initially. Com. practitioners, especially once they have staff privileges, will teach and teach well--and they are the backbone of any practice program established here. I really would like to see them functioning in the proposed

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ambulatory care center--rather than see it become an experimental station for the faculty".

- (16) * "An opportunity to use the faculty for care of their patients in whatever capacity they are qualified with supervision as decided by the responsible service."
 - * "Participation encouraged in post graduate conferences etc. to gradually improve by participation in their general qualification.
 - * "To have them as active participants".
- (17) * "Clearly, community practitioners stand to gain immeasurably through presence of Drew in community in which both practitioners and school serve. Practitioners' knowledge of and skills in medicine and health care delivery will be enhanced in proportion as practitioners work cooperatively with Drew. But cooperation between school and physicians moves along "a two-way street"; Drew must take the initiative in inviting and facilitating cooperation, particularly where practitioners desire staff appointments in the King-Drew complex. Imaginative approaches to physicians lacking qualifications for such appointments would still enlist those practitioners in the Drew efforts to upgrade delivery of health care in community".

C. Supporting Staff

- (1) * "A learning/sharing of perceptions - growing into programs which benefit the community and the Drew School - both so that each is mutually supportive of the other. They are different!"
- (2) * "They should be complementary to each other".
- (3) * "There should be the closest relationship possible between the community practitioners".
- (4) * "Total involvement in all aspects of health care for the community".

APPENDIX 3

Feedback Report No. 5
(Statistical Summary)

TO: Drew Faculty and Staff

FROM: Master Plan Study Consultants:
Jim Dunlop
Gene Grigsby
Jessie Smallwood

SUBJECT: Feedback Report #5
Questionnaire Responses; statistical summary

Introduction

In our initial discussions with members of the Faculty, Administration, Staff, Board Members, Community Physicians and Community Residents, it became increasingly clear that there were a variety of attitudes and expectations about the Drew School and its role held by several different groups. It also became clear that these different and sometimes conflicting perceptions and expectations were not shared; that is, the holder of one point of view was reluctant to acknowledge (or be aware of) other points of view, and certainly did not accord other points of view much validity.

It also became apparent to us -- and was very apparent to several of the people with whom we spoke -- that within the faculty there was a trend toward departmental "isolation"; i.e., "you do your thing and I'll do mine". There were and are notable exceptions to this, of course. And the faculty at Drew probably works together more than the average medical school faculty in this country today. But, enough people we talked with emphasized the need for Drew to "come together" or "improve its internal communication" or "relate to people in other departments as people" that the probable need for greater internal cohesiveness was at least indicated.

Why dwell on "perspectives" and "internal relationships" at all? Aren't different points of view desirable in an academic institution? Isn't the development of strong, independent departments a requirement for a strong, financially sound medical school? The answer is, of course, yes in both cases -- up to a point. But, unless the contending perspectives are allowed to be aired and confront one another, there is little chance to develop broader, more useful perspectives which, in turn, can help the institution move forward or permit people to find points of agreement. At a minimum, surfacing those contending perspectives can permit people to understand each other better without having to resort to questioning and impugning their motives. At a maximum, a new perspective can be shaped which can encompass old perspectives and enable Drew to move ahead faster and move adequately as an institution.

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From: Master Plan Study Consultants:
Jim Dunlop
Gene Grigsby
Jessie Smallwood
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In the area of internal relationships, when an institution is confronted with pressures from its environment -- in this case community people -- the institution is able to respond only to the degree that it is "together". If the institution is not "together", then the response, if at all, will be limited. Also, one of the limiting factors plaguing most academic medical institutions in this country today is the lack of interdepartmental activity on a working level other than in the direct treatment of individual patients. Strong departments are vital, but there is also the institution as a whole to consider -- which should be more than just the sum of its parts (minus friction).

In view of all this, we as consultants felt strongly that, as a first step, a lot of information needed to be shared about different perceptions and issues which are alive in the Drew School. The questionnaires which were administered during August were a way of developing information on a more or less systematic basis. That information has been assembled and is now being shared. It can serve as the basis for further discussing dealing with direction for the Drew School and its program development.

In all, some 86 persons responded to the questionnaire. From the full time faculty and professional staff there were 54 responses. From the part time staff (most of whom are local practitioners) there were 25 responses. From the support staff there were seven responses (mainly from one department which involved all of its supporting personnel in answering the questionnaire).

The following are the responses to those questions which could be tabulated.

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Question #1 "Indicate by a check on the scale, the point which describes how well you think Drew as an institution is responding to the needs of the King-Drew Service area".

	<u>Neglibily</u>	<u>To the Minimum Extent to Get By</u>	<u>About as Well as Can be Expected</u>	<u>Actively Though Incompletely</u>	<u>Fully</u>	<u>Total</u>
Full Time Faculty & Professional Staff	3	6	21	17	2	49
Part Time Faculty & Professional Staff	1	2	9	8	1	21
Support Staff	0	1	1	3	0	5
Total	4	9	31	28	3	75

- Number of Responses -

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Question #2 "In terms of its priorities, Drew School should:

Respond first to the needs of the local King-Drew Service area bearing in mind but not being governed by the applicability of programs to a broader "National Constituency".

Respond first to the expectation of a "National Constituency" bearing in mind but not being controlled by the needs of the local King-Drew Service area.

Full Time Faculty
& Professional
Staff

51

1

Part Time Faculty
& Professional
Staff

23

0

Support Staff

6

0

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Questions 5 & 6 - Relationships among departments.

The data on these questions are too voluminous to present here but from an examination of the data, certain inferences and conclusions can be drawn. Those wishing to see the data may do so by contacting Jim Dunlop on extension 203, Drew School.

1. Of all the components of the Drew School, Allied Health feels the greatest need to move closer to other departments, especially to Community Medicine.
2. Pediatrics, Community Medicine and Surgery also indicate substantial desire to collaborate more with other departments; Pediatrics particularly with Surgery and Community Medicine; Community Medicine particularly with Allied Health, Obstetrics, Medicine; Surgery especially with Allied Health, Community Medicine and Anesthesiology.
3. Another notable indication of need to collaborate was Psychiatry with Pediatrics.
4. Obstetrics perceives its relationship with other departments to be reasonably close across the board.
5. The departments of Anesthesiology, Radiology and Pathology do not perceive the need to move much closer to other departments.
6. Medicine views itself (and is viewed) as having reasonably close relationships with other departments with only a modest impetus to move closer.

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Questions 7 & 8 "In so far as you are aware of specific Drew Programs which directly impact on the King-Drew Service area, what is Drew's position now and what should it be (with respect to community involvement)".

No community participation except as recipients of service or as trainees. Program development & implementation is a job for professionals.	Community opinions entertained if volunteered.	Active community participation in an advisory role to specific programs.	Active community participation in decision making but less than a majority control over the development & implementation of programs.	Community in a position to choose which issues & aspects of the program	Community control over all aspects of the program	Don't know what Drew's position is or should be.
---	--	--	---	---	---	--

A. Full Time Faculty & Professional Staff

Drew's Present Position	3	14	7	8	1	12
Drew's Position as it Should Be	2	11	19	12	3	

B. Part Time Faculty & Professional Staff

Drew's Present Position	2	6	2	2		13
Drew's Position as it Should Be	1	7	11	4	1	

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Question #12

-Number who marked the priorities listed-

	1st Priority	2nd Priority	3rd Priority	4th Priority	5th or lower Priority
A. <u>Full Time Faculty & Professional Staff</u>					
1. Drew School exists to deliver <u>health & health education services</u> to the King-Drew Service area.	17	15	5	2	2
2. Drew School exists to upgrade (by training, supporting other health agencies, continuing education) <u>the general level of health in the community.</u>	23	13	4	1	0
3. The Drew School exists to help the <u>King Hospital</u> not be "just another county facility".	2	0	7	9	20
4. The Drew School exists to provide <u>economic upgrading</u> of the service area through jobs & training for community residents.	3	4	9	17	9
5. The Drew School exists to provide <u>continuing education opportunities</u> for community physicians.	1	6	16	8	7
6. Other	1	0	0	0	0
B. <u>Part Time Faculty & Professional Staff</u>					
1. Drew School exists to deliver <u>health & health education services</u> to the King-Drew Service area.	8	6	6	1	1
2. Drew School exists to upgrade (by training, supporting other health agencies, continuing education) <u>the general level of health in the community.</u>	11	12	1	0	0

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Question #12 (Continued)

	<u>1st</u> <u>Priority</u>	<u>2nd</u> <u>Priority</u>	<u>3rd</u> <u>Priority</u>	<u>4th</u> <u>Priority</u>	<u>5th</u> <u>Priority</u>
3. <u>Drew School exists to keep the King Hospital from being "just another county facility".</u>	1	1	3	6	11
4. <u>The Drew School exists to provide economic upgrading of the service area through jobs & training for community residents.</u>	1	1	5	9	6
5. <u>The Drew School exists to provide continuing education opportunities for community physicians.</u>	3	4	8	6	2
6. Other	2	2	0	0	1

C. Support Staff

1. <u>Drew School exists to deliver health & health education services to the King-Drew Service area.</u>	1	2	2	0	1
2. <u>Drew School exists to upgrade (by training, supporting other health agencies, continuing education) the general level of health in the community.</u>	5	0	1	0	0
3. <u>The Drew School exists to help the King Hospital not be "just another county facility".</u>	0	2	0	1	3
4. <u>The Drew School exists to provide economic upgrading of the service area through jobs & training for community residents.</u>	0	1	1	3	1
5. <u>The Drew School exists to provide continuing education opportunities for community physicians.</u>	0	1	2	2	1
6. Other	0	0	0	0	1

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Question # 12 (Continued)

Reasons given for Drew's existence, in addition to choices listed in the questionnaire.

A. Full Time Faculty & Professional Staff

1. "The Drew School has as its mission to investigate new means of health care delivery in order to upgrade the health of this service area and others like it everywhere". Rank: 1
2. "Drew School exists to contribute new knowledge to health care delivery field, biomedical science, community health education and awareness". Rank: 2
3. "To provide an educational environment to attract top quality health care professionals". Rank: 5
4. "Not other but a question--is a postgraduate medical school an educational (academic) institution?"
5. "To encourage and inspire people of this area to participate in doing something constructive (that is in the health field) to improve their present condition".
6. "Academic institution for development of innovative ways to deal with community problems".
7. "To provide a model for delivery of urban health care".
8. "To see if we can create an academic institution with research, etc., and at the same time deliver care which is responsive to the community and give recognition and prestige to those who are creative in developing better health care delivery systems".
9. "As a viable education and medical model for planning, organizing and directing health services for the black community with implications for all minority communities".

B. Part Time Faculty and Professional Staff

1. "The Drew School exists to give academic support to the King Hospital and thus assure high quality health care for the community". Rank: 1

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Question #13 "In terms of the next 12 months, what is the most important task facing the Drew School".

	Full Time Faculty & Professional Staff	Part Time Faculty & Professional Staff	Support Staff
a. Develop a more solid base of financial support.	5	4	1
b. Get itself together internally by developing ways of constructively dealing with conflict and working more cooperatively.	14	4	1
c. Developing & re-orienting programs & services to become more relevant to the needs of the King-Drew Service area.	14	4	2
d. Involving the community, including community practitioners, more fully in the program development activities of the school.	10	9	2
e. Other	5	1	0

Question #13 (continued) Most important task facing the Drew School over the next 12 months--comments in addition to choices listed in the questionnaire.

A. Full Time Faculty & Professional Staff

1. "To develop itself as a decisive force in the community. To become a place where the community including practitioners can look to with confidence and without the wide-spread suspiciousness which seems to currently prevail".
2. "To define and begin to implement the goals of the school in specific terms - hopefully, the development of model health care networks."
3. "Develop a common priority system for programs in the context of a proposed total system of health care delivery".
4. "Developing a sense of Drew School amongst its faculty. As of now the school is still an ethereal concept and one doesn't know where or what it is as there is not the sense of school".

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Question #13 (continued)

5. "Define the goals of the School and develop a program which can begin to be implemented, and evaluated as to the accomplishment of those goals".
6. "Decolonizing the minds of administrators and employees".
7. "Conflict will always exist but it should not drain one's energy and efforts away from more important matters and priorities".

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Question #16

Do you believe that the Drew School should design & implement some sort of model health care delivery system for the King-Drew Service area?

If yes, should it be limited to a small population group or should it extend as rapidly as possible to the entire service area?

	<u>Yes</u>	<u>No</u>	<u>Limited</u>	<u>Extend to Entire Service Area</u>
Full Time Faculty & Professional Staff	46	3	16	29
Part Time Faculty & Professional Staff	18	6	9	7
Support Staff	6	0	4	2

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Question #18 Indicate your feelings with respect to Drew's present line of development.

	Drew is moving in a direction which is opposite to my own personal goals and to the reason why I can here in the first place.	Drew could move in about any direction and it wouldn't make much difference to me, so long as it stayed alive and was able to pay my salary.	I'm not very aware that Drew is moving in any particular direction, but it seems O.K. to me.	Drew is moving in a direction which is generally consistent with (and certainly not opposite to) my personal goals.	Drew's development and my goals are all in the same direction.	Drew is the most exciting place I could imagine to work. It provides me full opportunity to realize my personal goals.
Full Time Faculty & Professional Staff	2		11	23	4	3
Part Time Faculty & Professional Staff			5	8	5	2
Supporting Staff	1		1	3	0	

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Question # 19

- a. The School of Allied Health Sciences should be as separate and autonomous as possible from the Drew School.

	<u>Agree</u>	<u>Disagree</u>
Full Time Faculty & Professional Staff	1	46
Part Time Faculty & Professional Staff	2	20
Support Staff	0	6

- b. The Dean of the Faculty of Allied Health Sciences and the Dean of the medical school should relate as equals with respect to the Board of Directors.

	<u>Agree</u>	<u>Disagree</u>
Full Time Faculty & Professional Staff	15	28
Part Time Faculty & Professional Staff	10	11
Support Staff	4	2

- c. Faculty members of the School of Allied Health Sciences should be given concurrent appointments in the Drew School.

	<u>Agree</u>	<u>Disagree</u>
Full Time Faculty & Professional Staff	37	6
Part Time Faculty & Professional Staff	16	4
Support Staff	2	2

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Question #19 (continued)

d.

The School of Allied Health Sciences should be the primary service arm of the Drew Complex in terms of mounting community based training programs.

	<u>Agree</u>	<u>Disagree</u>
Full Time Faculty & Professional Staff	36	9
Part Time Faculty & Professional Staff	16	6
Support Staff	4	1

APPENDIX 4

REPORT ON THE PILOT STUDY

Produced by

The Urban Workshop, Inc.

REPORT ON THE PILOT STUDY

THE PILOT PROJECT

Given the fundamental task of conceptualizing a health care network capable of serving the diverse elements within the service area, the demonstration or pilot project (Task 2b) was designed to initiate, build, and test projects jointly sponsored by Drew and the community. The project approach sought to address the following issues:

1. The health care delivery system is required to serve a broad sub-regional area.
2. The health system is required to serve not only the various population communities and sub-communities within the service area but to bridge cultural, class, and caste schisms in the process.
3. Health care problems vary directly according to the socio-economic characteristics of population elements within the community. The variation is related in some instances to specific locations (e.g., public housing projects, the Avalon/Central [the northern portion of the service area]) while other differences are shown by health and socio-economic data (e.g., low average age under 16 in Watts/Willowbrook and high unemployment throughout the service area).
4. A specific location, community, or population was considered to be most useful in order to bring into focus some of the specialized aspects of health care related to King-Drew.
5. The Watts community* with its concentration of low income residents, the majority of whom live in public housing, represents a significant demand on the health care system.

COMMUNITY ACTION ERA

The period of the last decade has been referred to as the Second Reconstruction. South-central Los Angeles has been one of the principal

* The Watts community is geographically defined for the purpose of this discussion as that 2.8 square mile area located within the southern portion of the King-Drew service area, extending north to 92nd Street, south to Imperial Highway, west to Central Avenue, and east to Alameda Street, within the city of Los Angeles. This area is immediately north of the MLK Hospital site, located in Willowbrook (Los Angeles County).

urban arena for the acting out of this process. Given the events of the mid and late 1960's--with the intensive and rapid emergence of community action programs followed by an equally rapid decline in the early 1970's--King-Drew remains as one of the few community-based entities that will be able to sustain its operational base and the development of health services over the long haul. King-Drew may be the most important entity of the past decade in terms of its socio-economic potential for the south-central area.

An indigenous perspective of the sequence of events during recent years is one of optimism, hope, expectation, and pride during the proliferation of action programs followed by the apathy and pessimism during the decline of the overall community development activity. No extensive discussion of the issues and contributing factors to the general ineffectiveness of programs and policies designed to improve socio-economic conditions (the magnitude of the activity was summarized in Phase 1) has been undertaken.

The interface between the local community development process and the problems related to health care, though important, are for the most part beyond the scope of this portion of the Master Plan process.

The significance to King-Drew is that the acknowledged urban crisis which propelled the events of the 1960's (i.e., the human conditions) have continued to decline as have resources for improving those conditions. Communities within the service area are apparently continuing on a path of irreversible decline which seriously constrains the capacity of King-Drew to operationalize a health care network throughout the service area.

Conditions of increasing poverty and eroding environmental conditions describe the socio-economic status of the community to a great extent. There are presently a number of stable middle-class housing enclaves developed for the most part toward the southern portion of the service area. However, these areas and their populations too are aging.

PUBLIC HOUSING

Statistics show 12,000-15,000 residents living in public housing projects located in the Watts community and indicate that 40-50% of the 30,000 residents live in the four projects within the 2.8 square mile area. The residential pattern and socio-economic and cultural structure of the community is to a great extent shaped and dominated "the Projects," (an indigenous reference to public housing). [See Figure 1.]

Of the six public housing projects located within the primary King-Drew service area, four are located in Watts. These projects with the number of dwelling units, estimate of population size, and acreage are summarized below:*

* Source: Los Angeles Public Housing Authority

PROJECT NAME	Total No. Dwelling Units	Total Area in Acres	Density (Dwelling Units/Acre)	Date of Completion
Hacienda Village	184	34	6	1942
Jordan Downs	700	15	45	1953
Imperial Courts	498	36	14	1954
Nickerson Gardens	1110	68	16	1955
Totals:	2492	153	16.4 (Av.)	

It is important to note that there is variation and diversity between public housing areas as there are between other communities within the service area. The density as indicated above varies from a low of six dwelling units per acre, the single-family residential density of Hacienda Village, to high of 45 dwelling units per acre in Jordan Downs, which is one of the highest residential densities in the county. There is apparently a causal link between the environmental conditions, housing density, and the general erosion of socio-economic conditions within "the Projects." The site of MLK (the Hospital) was formerly a World War II temporary housing project, whose residents were relocated in order to make the site available for MLK.

The concentration of public housing within Watts places the influence of low income communities at the center of the whole sequence of events following Watts 1965 (i.e., the surge of governmentally sponsored community action projects).

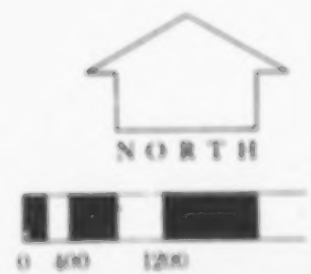
COMMUNITY PLANNING

A major dilemma of considerable magnitude is now evident with respect to the development of King-Drew, the point in question being that of economic development. The health institution is dependent upon linkages with the community in order to sustain and develop a health care network. King-Drew, as a model of "community medicine" with an economic component, if successful could serve as a viable model for emulation in the future, provided the thrust toward community development can be maintained.

If the present period is one of transition between the ill-fated efforts of the 1960's and the yet-to-formalize efforts of the 1970's, the King-Drew model of institutional development is placed under even greater stress. This



FIGURE 1



is an unfortunate consequence of the vacuum with respect to community resources left by the end of the war on poverty.

A critical pattern is discernible throughout the process of community development. This is essentially a pattern of failure in which community-oriented programs are unable, for a variety of reasons, to serve the target population or the primary objectives as stated. This generalization applies to the process of urban renewal, economic development, job development, education, etc. It is difficult to conclude that the provision of health care will be an exception to this general rule.

The above discussion is an attempt to delineate briefly some of the major forces shading the process of community participation. The project team from its inception in 1970 set out to develop strong linkages with the community residents. Growing out of the experience in the local community and other urban areas, a concept was established which sought to develop community skills by direct participation in the planning process. Thus, the term "Community Planners" was coined to identify those residents of the community that would participate in the planning process during the course of the Master Plan effort.

It was recognized that the limited financial resources for professional services would be a major constraint to the participation of residents in the planning process. However, the policy of the planning team had been to identify, train, and pay community residents for their participation in the planning process. During Phase I, the participation of the Community Planners was focused around the development of data from a survey instrument in the Watts-Willobrook area. Further efforts were undertaken by the project team to assist community residents in acquiring additional resources for community participation, not only in health but in related problems, e.g., crime, delinquency prevention, job development, housing, etc.

Programs and proposals were developed around the problems of one of the public housing areas (Jordan Downs). The strategy attempted to utilize both community action (OEO) and Model Cities resources. Unfortunately, no commitment of additional financial resources to expand community participation aspects of Master Planning was forthcoming.

During the second phase of the Master Plan process, a group of Community Planners from the Jordan Downs area were identified as the major participants in the planning process. The primary objective of the community planning activity was to establish an approach whereby Drexel could directly link with residents in the lowest income and "multi-problems" communities in order to initiate programs that would, hopefully, serve the populations beyond the scope of the traditional health care model.

The Community Planners, as a group, were residents of the Jordan Downs area in the mid-twenties age group. The participants without exception had police records and seven of the eight were on probation or parole for

misemeanor and felonious acts. Unfortunately, these are the "average citizens" from the youth and young-adult population in the south-central area. A recent study of the labor market indicates that the entry level job in the south-central area for a teenager is in the drug traffic. This study could be the basis for a re-evaluation of the economic structure and development of the service area.

Perhaps it would be well to look at some of the activities which were a part of the training process for the Community Planners in order to fully understand the value of such an endeavor.

For the most part, the efforts of those who have sought to develop programs for the urban poor have centered around the development of housing for the poor. There is no question that the lack of adequate housing and shelter can be directly linked to the increase in health problems for a community. It is also known that in order to meet these primary needs, the residents of a community may often forego the "luxury" of securing health needs in an effort to solve the more pressing need of housing. Part of the training of the Community Planner was thus to give them a better understanding of some of the programs related to housing in order to assist them in the solving of primary problems. By acquiring skills in this area, they would be in a much more advantageous position to then assist other community residents even more in the next area, that of meeting their individual health needs. Knowledge of community medical resources is also an important aspect of the development of an effective network of community health care. Although this aspect of the project did not reach the level expected, it is hoped that with additional training, the Planners could become an active part of the efforts of the King-Drew complex to expand the general knowledge of the community regarding specific health needs.

Perhaps the importance of the participatory model for community planning is that the residents are involved in some way in the planning process. All too often the attitude of the planner is that it is difficult enough to plan without having a group of community persons who have no expertise in the field having input into the process.* As more and more individuals are given the opportunity to participate, the general ability of the community to plan its own activities will be greatly enhanced.

As noted earlier in the report, the training of the Community Planners did not develop to the degree that we had anticipated at the inception of the project. One of the primary causes of this seemed to be the fact that effective ways of involving this strata of the population in the planning process have not been properly developed. Given the background of most

* Brooks, Wendy Goepel. "Health Care and Poor People," in Edgar S. Chan and Larry A. Passett, eds. Citizens Participation: Effecting Community Change. New York: Praeger Publishers, 1971, pp. 110-128

of the participants, perhaps the most important contribution at this point is that they were at least exposed to the multitude of activities which are a part of the program development process. The degree to which participants of this nature can be effectively integrated into program activities may hold suggestions for future endeavors of this kind. These considerations might include some of the following:

1. Numbers of participants to be involved in a single project;
2. Number of professional staff needed to handle the complex problems which they may bring to the project;
3. Clear delineation of the areas which will be most useful for training purposes;
4. Selection process for the participants.

In conclusion, the following point cannot be over-stressed: one of the primary functions of involving the lower strata of the community population in the planning effort may be its unique contribution toward putting the entire thrust of the health care effort into perspective. More often than not, the present problems of the client group [the King-Drew complex] may not be the most pressing or important to the community. This was amply pointed out by the interests of the Community Planners. Their priorities were in the areas of maintaining some kind of economic stability in the face of the many impinging forces, e.g., their criminal records, which were a constant threat to their remaining free in society.

In effect, their message to King-Drew was that their primary interest was in economic development which would ensure that they could continue to function freely in society. If these needs were met, they would be in a position to spend more time considering other problems such as health care in the community.

If Drew is indeed able to bridge the gap between a traditional model of health care delivery and that of an economic development model, it will truly emerge as an innovative and meaningful approach to meeting the needs of the urban poor. This goal is not easily attainable nor is it one which the current and/or projected budget of the institution can easily bear. Perhaps it will only be through the efforts of a department such as Community Medicine, acting in concert with other community resources, that the stated goal, "a general improving of the health care delivery and health of the service area," can be fully realized.

Two major reports were identified under Task 2b as resource material for the planning of special aspects of the health care delivery system. The reports address the major problem areas directly related to Task 2b,

the labor market and the problems of drug abuse. These reports are:

Youth and the Labor Market
Manpower Research Center
Paul Bullock, UCLA

Community Resources in Alcoholic, Drug Abuse
and Delinquency Prevention
J. C. Ries, Barbara Gross, and Alene Pette
Institute of Public and Governmental Affairs 1972
[Study conducted for Los Angeles Council of Criminal Justice]